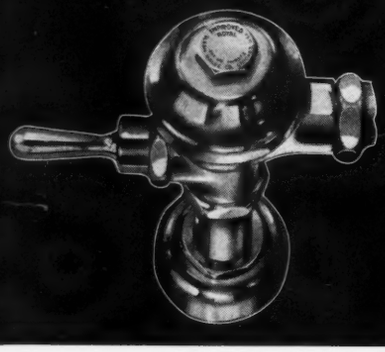
the MODERN HOSPITAL

VOLUME 65 JULY 1945 NUMBER 1



32 years of service for SLOAN FLUSH VALVES

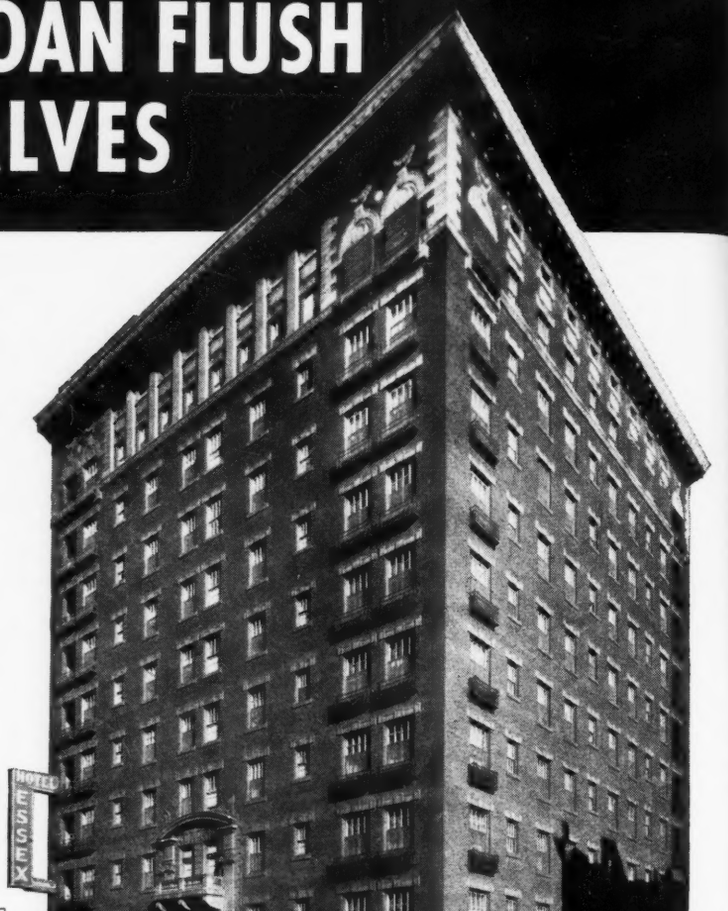
THE ESSEX HOTEL, Philadelphia, (formerly the Vendig Hotel) was extensively rehabilitated and modernized several years ago. Yet—the Sloan Flush Valves which were a part of the original equipment have never been replaced. They are still in excellent operating condition after 32 years of continuous service.

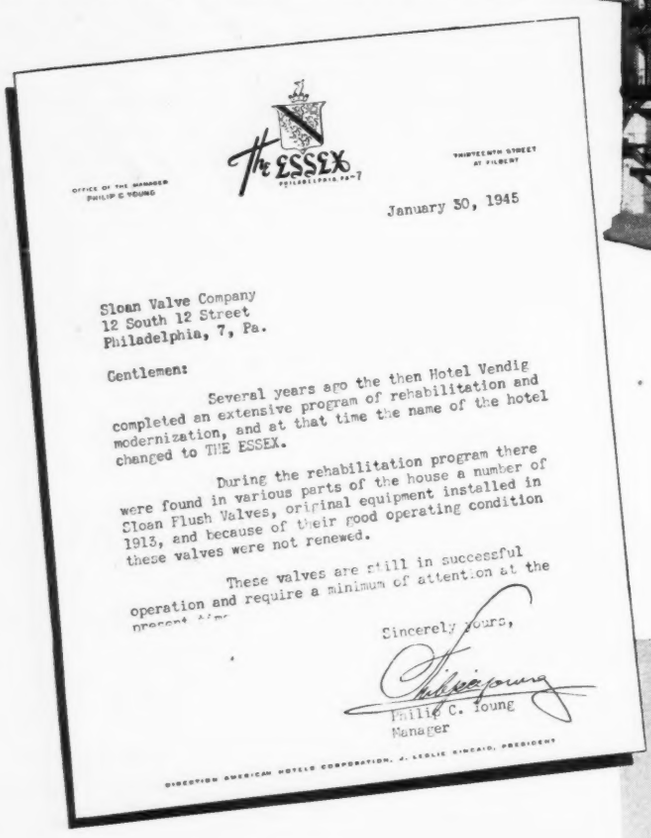
For the man who pays the bills, this service record will point the way to his logical choice of Sloan Flush Valves for buildings of the future.

We urge *you* to make inquiry of performance records—water saving records—and low maintenance cost records. You will find Sloan Flush Valves *unequalled* on all counts—three of the many reasons why Sloan is the world's most popular Flush Valve.

Yes—there are millions more Sloan Flush Valves in service than all other makes combined.

SLOAN VALVE COMPANY
4300 WEST LAKE STREET, CHICAGO 24, ILLINOIS





The ESSEX
PHILADELPHIA, PA.-7

OFFICE OF THE MANAGER
PHILIP C. YOUNG

THIRTEENTH STREET
AT FILBERT

January 30, 1945

Sloan Valve Company
12 South 12 Street
Philadelphia, 7, Pa.

Gentlemen:

Several years ago the then Hotel Vendig completed an extensive program of rehabilitation and modernization, and at that time the name of the hotel changed to THE ESSEX.

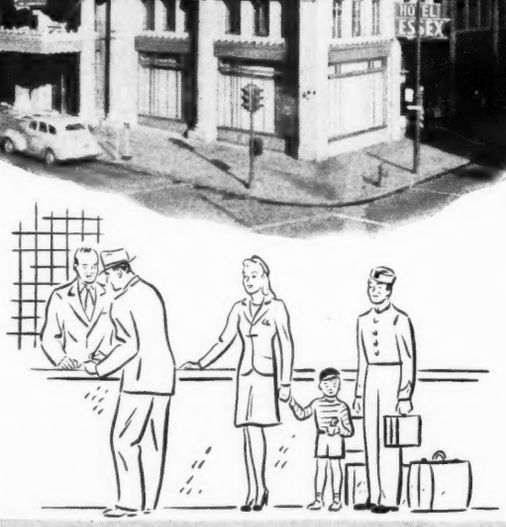
During the rehabilitation program there were found in various parts of the house a number of Sloan Flush Valves, original equipment installed in 1913, and because of their good operating condition these valves were not renewed.

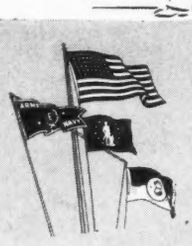
These valves are still in successful operation and require a minimum of attention at the present time.

Sincerely yours,

Philip C. Young
Manager

DIRECTION AMERICAN HOTELS CORPORATION, J. LESLIE KINCAID, PRESIDENT





Sloan Valve Company has been awarded the Army-Navy "E" three times for excellence in war production

CONTENTS

Published monthly and copyrighted, 1945. The Modern Hospital Publishing Company, Inc., 919 North Michigan Avenue, Chicago 11. Otho F. Ball, president; Raymond P. Sloan, vice president; Everett W. Jones, vice president; Stanley R. Clague, secretary; James G. Jarrett, treasurer. North and South America, $3 a year; foreign, $4. Single copies: current, 35c; back, 50c to $1. Entered as second-class matter, Oct. 1, 1918, at the post office at Chicago, Ill., under act of March 3, 1879. Printed in U.S.A.

GOVERNMENT *Affects Our Future*

WILLIAM S. BRINES
Superintendent
Central Maine General Hospital
Lewiston, Me.

PROGNOSTICATION, many say, is a dangerous business, and forecasting futures is a sport for seers and kings. With such a bromide I do not agree. It is the privilege and responsibility of every individual to look into the future, for, regardless of the proved accuracy of the conclusions, thinking and progress both lead to the future.

This discussion will be limited to a projection stemming from three major influences: Bill S. 191, or the Hill-Burton Bill, the future policy of the Veterans Administration and the possibilities evoked by social legislation affecting the "health and medical security" of this nation. Of course, this plots a tremendous field for thought and much must be eliminated.

Legislation Weighed First

Since it is probably the broadest field, therefore less adequately discussed, possible federal legislation affecting the medical and hospital care of "We, the People" might best be weighed first. A broader knowledge and understanding of health and security have led to a lively interest in this field. As a people we have become health and security conscious. The "New Deal," Blue Cross and insurance plans, Grange, Farm Bureau, unions, even hospital public relations programs, have had a hand in developing this attitude.

In itself, this is a good thing. Yet, like many good things, with popular interest, we find that its direction is being shouldered into the wrong path. As a vote-getter, national health is too rich a plum to leave on the branch until ripe. Already in the Murray-Wagner-Dingell Bill, an attempt is being made to pick it so that "no one else will get it" and in order that it may be ripened on the windowsill of government control.

Now anyone who has ripened plums this way knows that only an expert can prevent soft spots. Since because of its unwieldy and decidedly inept makeup the government is not an expert, if such health-controlling legislation is approved the soft spot is inevitable. And this particular rot develops in us for not assuming the responsibility for our own welfare. Passing the job along to neighbors in Washington automatically destroys one more spark of initiative in our spirit.

Only an awakening of unprecedented magnitude among the voters will change the present course toward government control of medicine and hospitalization. The germination of such an awakening is alive in such efforts as the nonprofit Blue Cross plans but action must be quick to prevent federal legislation. In my opinion, it won't be quick enough and Congress, unless guided more firmly by voters, will jump the gun and include medicine under the Social Security Act.

Such hospital medical benefits as are included will cost the people far more and will provide far less than had it been handled by nongovernment competitive insurance plans. Coverage will not be satisfactorily complete and both the provider and seeker of service will be inadequately compensated. The government simply cannot handle an administrative job as efficiently as can private initiative.

It is still possible that the forecast of government-controlled health protection may be proved wrong by our efforts. I sincerely hope so, for it is far more desirable to take an alternate course.

Here is one possible way: Let the federal government, with the help of qualified experts, set up a scale by which indigency or semi-indigency can be measured, then by adequate taxation assist states in providing full compensation for the services such persons receive based upon cost. At the present time, this is not done and the various eleemosynary institutions, foundations and other private charitable organizations must carry a major portion of the national indigent care expense.

Require Basic Insurance

Above this level, in the same manner as one is required by some states to have basic automobile insurance before licensure, let us be required by government to take out medical and hospital insurance, wherever we want to get it and on whatever basis we wish, provided it is sufficient to meet the need. Medical-hospital insurance is decidedly low-cost protection and would not hurt the slimmest pocketbook.

The Veterans Administration with its ambitious policy for its own future through medicine is an influence of major proportions on postwar hospitalization. Within five years, the Veterans Administration plans to be operating 300,000 beds, this in spite of a long history of low medical and professional standards and general unpopularity.

More than one article has been released recently concerning the mismanagement of hospital and medical care by the Veterans Admin-

istration. It is my opinion that the subject goes far deeper than these serious but superficial accusations. To help adjust our war-conscious minds to the problem of hospitalization for veterans, above all one must remember that the subject embraces not only the immediate but the life-long needs of the former serviceman.

The end that all citizens desire is to give A-1 hospitalization and medical attention to veterans, whether service-connected or nonservice-connected distress is involved, when needed, for a lifetime. The means toward that end, as selected by the Veterans Administration, has in many categories not been fundamentally sound, particularly reasonable and practical or, indeed, even very successful.

Care Divided Into Four Classes

Generally speaking, medical care for veterans may be roughly divided into four classifications: neuropsychiatric, tuberculosis, domiciliary (chronic) and general. There is one failing common to all four except in the few isolated cases. In spite of many capable men in this bureau, this failing is incompetent personnel. Nor is this, like so many, a war-time condition. It is prewar, present and postwar and, unlike most, the situation in quality, if not in numbers, has been, if anything, bettered by war conditions.

We voters, as thinking individuals, evidently have not had much interest in this vital service. More than any vote-getting social measure, it's a Congressional "must." We bow, scrape and doff our hats because "nothing is too good for 'our boys'" and jump at the throat of anyone who even suggests opposition as being a Doubting Thomas.

I thoroughly oppose not only the present program but the future program as well for two different reasons: (1) "the boys" are not getting the best after they leave the service and (2) the cost for what they do get is too high.

For instance, let us measure the common ill—incompetent personnel. Why, after hundreds of millions of dollars have been tossed by Congress into the Veterans Administration's lap, can't good key personnel be obtained? It seems just a little silly that one of the answers is poor pay; another, of course, is political paternalism in employe selection.

The pay classifications are cut and dried. A doctor starts at $3200 a year and can attain $6400. Maintenance, it is true, is provided, but the location of these isolated institutions usually offsets any financial gain. Needless to say, such compensation is far below that which a good doctor would receive in private practice where he could live in normal surroundings as a member of a community instead of isolated in a remote institution.

Consider what this man has invested in both cash paid and invested earning capacity. Even at a salary of only $2500 per year he would have earned $10,000 in the four years he spent in undergraduate school and another $10,000 while he was a medical student. With just the minimum requirements—a single year's internship—another $2500 is lost. But his education costs something, too, roughly $7500.

In other words, the doctor is offered $3200 a year after theoretically investing about $30,000 in preparing for the job. Stir into this recipe all the other influences that result from low-grade, poorly directed personnel and it is a poor batter for baking the bread of life.

We have still to explain the expenditure of the tremendous appropriations of money for the care of veterans. It will be found in costly physical plants, clumsy administration, high per patient cost (especiallv for the product received) and a rather surprising "goldbricker" expense.

A panacea does not exist, but there might be a good solution for the problem of veterans' hospitalization. First, the bureau should be shaken from its high-power politics position and, having cleaned its own administrative office of less competent personnel, should forget the personal desire of control and devote its energies permanently to providing what taxpayers are trying to buy—good hospitalization.

Second, the major portion of existing facilities should be devoted permanently to neuropsychiatric care.

Third, its medical services should be properly conditioned and then hospital care of the tuberculous should be limited to those beds that already exist until circumstances warrant expansion. At the same time, the veteran should have the right to go elsewhere, and the reasonable cost of such service should be provided.

Fourth, the so-called "domiciliary" hospitals should be discontinued entirely and in their stead veterans' homes should be provided.

Fifth, general hospital service as a Veterans Administration function should be discontinued and the care provided in community facilities with the services paid for at cost by the Veterans Administration.

I have heard veteran officials scoff at the thought that the per diem cost in a community hospital was lower than that in one of their huge institutions. It is interesting to me, though, that they forget to include the outrageous cost of their plants, their empty beds and, particularly, the cost of transportation of the veteran patient to and from his home. It is true that veterans' facilities are able to avoid some of the cost of being educational institutions, but they do not avoid the cost of extended care caused by slow recuperation.

If we are honest in our desire to provide the best for those who were asked to give their best, why must a former serviceman, to obtain the benefits we provide, have to leave home, friends and familiar surroundings to obtain hospitalization? The happier course, resulting in quicker recovery, would be to let him go where he chooses.

Let Veteran Choose His Doctor

Why deny the veteran the choice of physician, perhaps the man who has cared for him for a lifetime, and by mandate (practically "take it or leave it") consign him into a medical machine? Whether second rate or first rate, what could be more "socialized" than this!

Why must the veteran be placed in close contact with the influence of the impossible-to-eliminate institutional bum or "goldbricker," together with institutionalized food and routine, without friends or relatives to help his state of mind improve his body?

Place yourself in a veteran's shoes. Would you take it? My guess is that you would do exactly what the record shows the majority of veterans have done in the past. You would pay your own way in the manner you want and leave the government facilities to those who can't pay or who wouldn't carry their own weight under any circumstances.

If our representatives in Washington seem no whit abashed at includ-

ing medical and hospital benefits in the Social Security Act, it just doesn't make sense to surmise that handling the program for veterans' medical needs on a free choice basis would be an administrative impossibility.

The Emergency Maternal and Infant Care program seems to have charted a sound basis for remunerating at cost. As a taxpayer, I'm sure that the average voter would prefer a higher cost for the physician's services if a veteran could choose his own man. Even if this did not cost us more, the over-all expense would be less per veteran cared for.

One of the questions that must be expected, should the veterans turn to the community facilities for general care is: Where will they be cared for? The answer is obvious: Where they always were cared for. "A man's a man for a' that" and being a veteran doesn't change a man into something queer. That's the trouble with handling the veteran like a commodity instead of a human being.

There will be some increase in the need for chronic disease and general facilities. I do not believe it will be tremendous but it must be provided for. Furthermore, our first thought for discussion, that of federal legislation affecting our medical needs, indicates a new era in medical and health demands, and the inevitable result is the need for expansion in hospital facilities. Some hospitals have already completed their plans and obtained the funds for expansion. Shifts in population will care for some, and the new Hill-Burton Bill, S. 191, the third point for discussion, may help fill whatever needs remain.

The Hill-Burton Bill is a good, well-planned effort toward providing the physical needs for our sound national health program. It has been enthusiastically received, evidently, by every interested organization, whether private or governmental in character. The fundamental intent is crystal-clear and completely justifies its passage.

Obviously, S. 191 is a U. S. Public Health Service measure. Its aim is to provide physical facilities necessary for a national health program where there is none or where they are insufficient. Not only does this motivating force justify such legislation, but it does so regardless of all other reasons. Incidentally, I believe this is the first time in legislative history that the various associations and agencies all agree on a federal measure.

I regret the introduction of the Federal Works Agency's services into the picture without more control. F.W.A. is, at least at present, too political an organization for such a position.

It is obvious that at present the most urgent needs will be the state or local government facilities, whatever their nature, and such allocation possibly penalizes the institution that has been producing the best and, frequently, most needed health service. We must begin somewhere, however, and this is as it should be. We all agree that low-grade and crowded institutions should be brought into physical fitness.

Two weaknesses threaten the activation of S. 191's intent, one comparatively minor, the other definitely great. In the first place, its enactment is based on needs determined by survey. Since all facilities fall within the survey, the program developed will include those not at all under government control. Simply because government funds are not granted should not, and would by no means, stop private expansion, and when unrecommended expansion inevitably takes place, the survey immediately becomes passé.

V.A.'s Future Is Great Enigma

The second weakness, and by far the greater enigma, is the Veterans Administration's future. If this bureau builds up the 300,000 bed total it plans, covers more than 10 per cent of our population and spares no particular thought to levels of necessity, it is inevitable that the present private initiative and public-spirited program will be thrown out of joint. Either that or the veterans' program will fail, leaving the U.S.A. a bankrupt dealer in real estate.

Perhaps this fairly brief discussion suffices to show the interdependence of these three all-important programs. Two are aggressive, one defensive, in our program of national living. Federal health measures will be enacted; the Veterans Administration, almost pugnaciously, will proceed with its hospital construction, doctors or no doctors, patients or no patients, and, in defense of health—especially in the poorer regions—health and hospital facilities will be provided.

I have endeavored to outline my opinions of these three forces, as 1/150-millionth of the nation's voting power. The effort was made in the hopes that interest would be aroused in some of the remaining voting power. As participants in the management of our nation, we do mighty little. Perhaps, instead of beating around the bush, we can, as grass roots, do a little "bushing."

Psychiatric Competition Is Still Open

The Modern Hospital's essay competition on "A Plan for Improving Hospital Treatment of Psychiatric Patients" has attracted a great deal of attention and several hundred copies of the announcement from the April issue have been mailed out on specific requests. Although the closing date for submitting essays is October 1, seven essays were already on hand by June 14! The competition is open to ANYONE except the judges and employes of the magazine. All others are invited, indeed urged, to prepare and submit essays promptly. Full details are given in the April announcement.

Psychiatrists, hospital administrators, social workers, public welfare officers, nurses, hospital employes and many members of the armed forces have indicated an interest in the competition. One of them writes: "I think this is an excellent idea and may bring forth some worth-while ideas in addition to keeping the subject before as many people as possible."

Contestants should bear in mind that their plans should not cover merely one segment of the problem but that they can attack the entire subject from a special point of view, such as that of an administrator, a nurse or a patient.

Nurseries Designed for MODERN MATERNITY

P. A. McLENDON, M.D.
Professor of Pediatrics

JOHN PARKS, M.D.
Professor of Obstetrics and Gynecology

George Washington University School of Medicine, Washington, D. C.

HOSPITAL administrators and practicing physicians have found it advisable and practical to do away with large wards for adult patients. However, many modern hospitals that have a maximum of four beds in an adult unit still maintain large nurseries for the collective care of their infant patients. In many instances, hospital authorities have learned too late that large nursery units are hazardous. It has taken epidemics of impetigo, respiratory infections and, more particularly, "neonatal diarrhea" to initiate a demand for changes in architecture. Hospitals in all areas of the United States have experienced the disaster of one or more of these tragic nursery epidemics.

Infant Mortality Can Be Reduced

While it is impossible to obtain comparable data over a period of years, information from the Bureau of the Census shows that in the eight year period beginning with 1935 through 1942 there was an 84 per cent increase in the number of women who gave birth to their babies in hospitals.[1] During the same period, maternal mortality was reduced 55 per cent while infant mortality, for the first month of life, decreased only 20 per cent.[2] The mortality rate for infants dying in the first month of life should and can be reduced a great deal. Improved nurseries can become the hospitals' contribution to a real reduction in the neonatal deaths which result from preventable diseases.

In many hospitals, partitions have been erected to break up large nurseries into smaller units. The result has been that many of these made-over nurseries have been left deficient in proper plumbing facilities, adequate examination and treatment rooms and necessary bedside working space. This condition has made for a healthy consciousness on the part of physicians of the architectural needs of the modern hospital, which *demand* radical changes in nurseries.

Foremost of these changes must be provisions for protection against infection. In addition, the structure of nurseries should be changed so that they not only serve as protected quarters but contribute as maternal centers of education in infant care and development. With these principles as a background, the following features have been incorporated in the plans for the new George Washington University Hospital:

1. It is recognized that one nurse can take good care of a maximum of eight normal infants at one time.[3, 4, 5] The arrangement of all of our nursery units is based on this premise. A nursing assignment will consist of one eight crib nursery or two four crib nurseries or eight one crib nurseries. Well-planned small nurseries, plus proper nursing technic, should eliminate cross-infections and epidemics.

2. Nurseries are the centers around which the mothers' rooms are planned. In these plans, patient rooms have been placed in relation to nurseries so that there will be a minimum of corridor exposure of the infant. This arrangement should reduce contact infection, facilitate nursing care and foster closer mother-baby relationships.[5, 6, 7]

3. Mobile "unit bassinets" will be used in all normal nurseries. This type of bassinet, on large casters, can be rolled to the mother's room and attached to her bed. The unit bassinet is constructed so that the infant's crib will swing over the mother's bed a distance of about 18 inches making it easy for the mother to lift her infant out of the crib. Infants will be handled less by nurses. Mothers will have an opportunity to learn more about their babies while in the hospital under the supervision of well-trained nurses.

Any Combination Available

4. A choice of nursery space for the infant will have a range in privacy and protection comparable to the room space provided for the mother. With a variation in size and location of unit nurseries, a patient may choose any combination of facilities she wants for her infant and for herself.

5. The mother's room and the infant's nursery space should be considered separately in the cost of care. In voluntary hospitals, charges for infant care rarely pay for nursery costs. Under any acceptable standard, good nursery care is expensive. In hospital economy, the infant should be treated as the important end-product rather than the by-product of the maternity division.

6. "Suspect" nurseries are provided without extra cost for the im-

[1]Vital Statistics—Special Reports, Live Births by Persons in Attendance, United States, 1942, Department of Commerce, Bureau of the Census, Washington, D. C., **19:**93 (March 24) 1944.

[2]Births, Infant Mortality, Maternal Mortality, U. S. Department of Labor, Children's Bureau Publication No. 288.

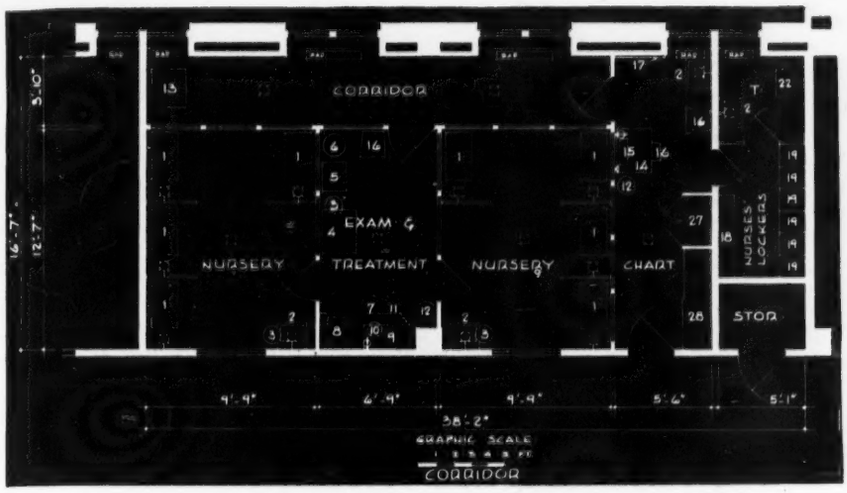
[3]Dunham, Ethel C. M.D.; Shaffer, Marshall, and MacDonald, Neil F.: Standard Plans for Nurseries for New-Born in Hospitals of 50 to 200 Beds, Hospitals **17:**16-21 (April) 1943.

[4]Standards and Recommendations for Hospital Care of New-Born Infants, U. S. Department of Labor, Children's Bureau Publication No. 292.

[5]Hospital Standards for Infant Care, Editorial: Medical Annals of the District of Columbia **14:**129 (March) 1945.

[6]Simsarian, Frances P., and McLendon, P. A., M.D.: Feeding Behavior of an Infant During the First Twelve Weeks of Life on a Self-Demand Schedule, Journal of Pediatrics **20:**93-103 (Jan.) 1942.

[7]Simsarian, Frances P., and McLendon, P. A., M.D.: Further Records of the Self-Demand Schedule in Infant Feeding, ibid.: to be published.



PREMATURE NURSERY SUITE

(Numbers omitted refer to items too small to show at this scale.)

NURSERY (EACH)

1—Bassinet unit
2—Lavatory
3—Sanitary waste receptacle

EXAMINATION AND TREATMENT ROOM

3—Sanitary waste receptacle
4—Treatment table
5—Table for scales
6—Linen hamper
7—Counter
8—Sink
9—Cabinets over counter
10—Electric hot plate
11—Instrument sterilizer
12—Waste receptacle
16—Chair

CHART ROOM

2—Lavatory
12—Waste receptacle
14—Charting desk
15—Chart rack holder
16—Chair
17—Hook strip
27—Gown cabinet
28—Linen closet

NURSES' LOCKER

18—Bench
19—Lockers

TOILET

2—Lavatory
22—Water closet

CORRIDOR

13—Refrigerator, 6 cu. ft.

is, in turn, closed off from the nurseries proper.

All partitions will be of clear glass providing a full view of the entire area from any point. Floors, walls and partitions are to be constructed so that there will be a minimum of dust ledges and areas inaccessible for cleaning. Individual lighting and "plug-in" units will be provided for each bassinet or incubator space. Corridor view windows with opaque sliding panels will permit parents to see infants.

The treatment room will be provided with all equipment and lighting facilities necessary for any diagnostic or therapeutic procedure. Lavatories will be located in each nursery, in the treatment room and in the entrance area. Adjacent to the entrance hall is a nurses' dressing room with lockers, toilet and lavatory which will be used exclusively by nurses assigned to the premature unit.

Eight Crib Nursery. For normal infants, the largest nursery has been designed to accommodate a maximum of eight cribs in individual cubicle spaces. Twenty-five square feet of nursery floor space is provided for each infant. Cribs will be separated by a glass partition. Each

---

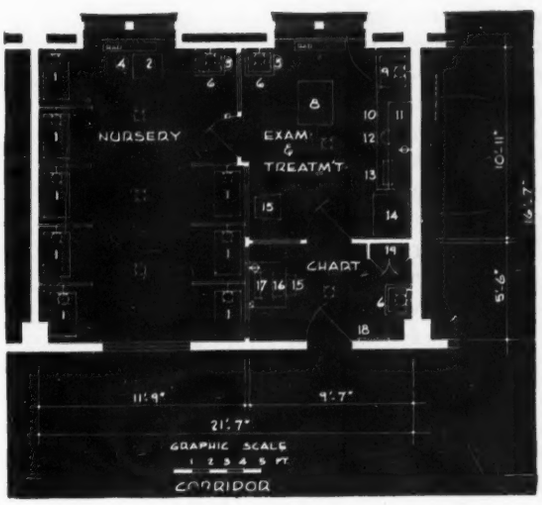
mediate segregation of infants showing the earliest signs of infection.[8]

7. Special units and personnel are provided apart from the regular nurseries for premature infants.

Nurseries for Premature Infants. Experience has demonstrated the necessity of a separate unit for premature infants supervised by specially trained nurses. In this plan, the premature unit is placed adjacent to the delivery suite to permit immediate transfer of premature infants from delivery room to nursery and for mechanical accessibility to air conditioning. Regulation of temperature and humidity control must be within the individual nurseries. A poorly regulated "conditioning" is worse than none at all.

As will be seen from the plan, there are three checks to corridor contamination: an entrance hall with a scrub, gown and chart area; a clean outer corridor, and, finally, the examination-treatment room which

[8]Merrill, A. P., M.D.: Suspect-Nurseries, The Modern Hospital **64**:49-63 (Jan.) 1945.



EIGHT CRIB NURSERY UNIT

NURSERY

1—Bassinet unit
2—Scale table
4—Waste receiver
5—Sanitary waste receptacle
6—Lavatory

EXAMINATION AND TREATMENT ROOM

5—Sanitary waste receptacle
6—Lavatory
8—Treatment table
9—Sink
10—Counter
11—Cabinets over counter
12—Electric hot plate
13—Instrument sterilizer
14—Refrigerator, 6 cu. ft.
15—Chair

CHART ROOM

6—Lavatory
15—Chair
16—Charting desk
17—Chart rack holder
18—Hook strip
19—Gown cabinet

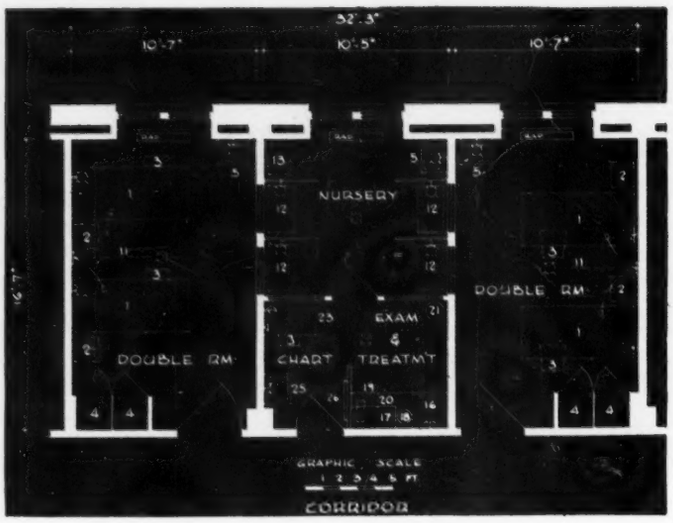
cubicle will be provided with a wall light and "plug-in" for attaching an aspirator, oxygen tent or any other necessary electrical device. The ceiling lights will be hooked up with a constant dim light and a switch for indirect flood lighting. The corridor viewing window will be of clear glass supplemented by a sliding opaque panel which will be controlled from within the nursery.

Each nursery unit will have its associated examination-treatment room, as well as a separate chart and gowning room. In the chart room the physician may examine the infant's record and view the baby through the glass partition. Before entering the examination-treatment room, it will be obligatory to scrub the hands and put on cap, mask, and gown. The individual crib will be rolled into the room and the infant will be placed on the bassinet table top for examination. Only the nurse will need to go into the cubicle area of the nursery. Equipment for any diagnostic or therapeutic procedure will be available at all hours in each examination-treatment room. Eight crib nurseries will be available to one, two and four bedrooms.

Four Crib Nursery. A choice of a more individualized nursery will be available for a certain number of patients occupying two bed rooms. The floor plan for the four crib nursery is essentially the same as for the eight crib nursery. There are an entrance chart and gowning room, an examination-treatment room and a four crib nursery with lavatory and other equipment as outlined for the eight crib nursery.

However, these four crib nurseries will be placed between two two bed rooms as illustrated in the plan. Four crib nurseries will be placed opposite each other on the corridor in order that one nurse can supervise the care of eight babies. Individually controlled double glass viewing windows will be placed between the mother's room and the nursery rather than on the corridor.

This design will reduce corridor exposure of the infant and lessen the possibility of mass nursery infection. It also permits the mother to have her infant for longer periods in which she learns its earliest behavior. The mother thus knows more about baby care before she leaves the protected confines of the hospital. It is understood that the infant will not be left in the mother's room during visiting hours and that visitors will be prohibited from entering this room during nursing periods.



FOUR CRIB NURSERY UNIT

BEDROOM (EACH)
1—Bed
2—Bedside stand
3—Straight chair
4—Locker unit
5—Lavatory
11—Curtain rod

NURSERY
5—Lavatory
12—Bassinet unit
13—Table for scales

EXAMINATION AND TREATMENT ROOM
16—Sink, counter type
17—Cabinets over counter
18—Electric hot plate
19—Instrument sterilizer
20—Refrigerator under counter
21—Linen hamper

CHART ROOM
3—Straight chair
23—Desk
25—Lavatory
26—Hook strip

Let us examine some of the disadvantages which may be voiced concerning this depature from previous methods of maternal-infant hospital management.

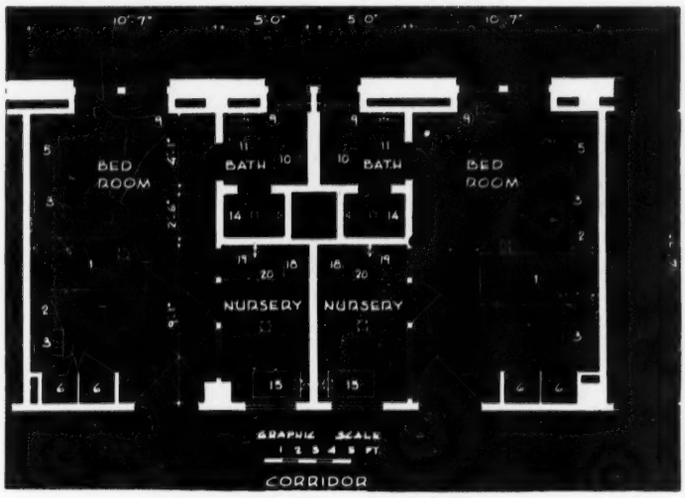
Cost of nursing care should be no greater than for any eight crib nursery. Floor space occupied by two four crib nurseries is exactly the same as provided for an eight bed nursery. Cost of duplication of equipment will be offset to a great extent by the purchase of smaller cabinets, desks and iceboxes for the four crib nurseries. Disturbances from infants' crying should be much less in nurseries that hold only four babies. Nursery noise does not penetrate walls nearly as much as it travels through door spaces.

It is contended by some that the mother will worry more about her crying infant. With her first baby, the mother who cannot see her infant will worry about any that she hears crying, thinking that it is her own. If the mother can see her baby, she will soon become acquainted with the cry of hunger and with the cry of discomfort which results from external stimuli, such as a wet diaper and a cramped position.

Suspect Nursery. The two suspect nurseries are based on the same design as the four crib nurseries except that viewing windows will face the corridor and one crib will be replaced by a treatment table so that all treatments can be carried out at the bedside of the infant. These nurseries will be placed adjacent to the isolation area of the maternity division away from other nurseries.

One Crib Nursery. Carrying the idea of smaller nursery units and mother-infant relationship one step farther, one wing of the maternity division has been designed to contain eight bedroom-nursery suites as shown in the plan. These individual nurseries are arranged with corridor viewing windows which permit one nurse to observe all eight infants without disturbing the mothers. Four rooms will have associated bath facilities, as well as attached nurseries. Each nursery will have all the essentials for good nursing care, including a lavatory.

For many patients, an individual nursery associated with a lying-in room will provide an ideal arrangement. The mother will have privacy for her infant as well as for herself.



BEDROOM, BATH, NURSERY UNIT

BEDROOM (EACH)

1—Bed
2—Bedside stand
3—Armchair
5—Dresser
6—Locker unit
9—Waste receptacle

BATH (EACH)

9—Waste receptacle
10—Water closet
11—Lavatory 20 by 18 inches
14—Shower

NURSERY (EACH)

15—Bassinet unit
18—Sink
19—Electric hot plate
20—Sanitary waste receptacle

In these units, the mother can have her infant's bassinet attached to her bed during a greater part of the day. When visitors are present, it is apparent that the infant should be placed in the nursery.

The mother will have the privilege of seeing and sharing in the early developmental changes that characterize the new-born and that can be appreciated only by more prolonged periods of observation than has been the practice in the hospital care of infants. By this plan, the mother will have an early opportunity to learn from her nurse the simple but disturbing first lessons of breast or bottle feeding, of eructating the infant, of diaper changing, bathing and body care.

Summary and Conclusions. The new-born infant should be considered a new patient admitted to the hospital by way of the delivery room. Hospitals should receive enough income from nursery charges to permit proper care of their infant patients.

Small functional units are the surest means of controlling nursery infections. In dividends of health, the mass management of infants in large nurseries is not economical.

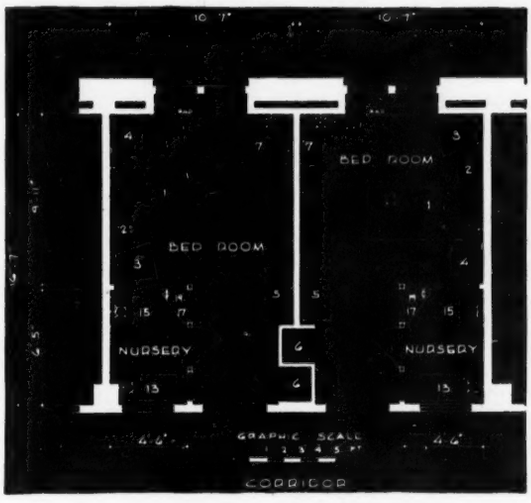
In our design, all normal nursing units conveniently add up to aggregates of eight cribs, the number to which one nurse should be assigned. Irrespective of the size or location of these units, they are so independently arranged that no infection need spread from one to the other without gross neglect in supervision.

The nurseries are planned and equipped to reduce to a minimum all external stimuli, such as noise, strong lighting and unnecessary handling of infants.

No matter what the total number of beds in the maternity division may be or what "floor plan" is used, the unit system of nurseries can be worked out. The wings and corridors of the new George Washington University Hospital make such an arrangement ideal.

With the nursery units in close proximity to the mothers' rooms, there will be greater opportunity to increase the time that babies can spend with their mothers. Encouragement in this early infant-mother relationship should be a tremendous factor in increased breast feeding.

The pendulum of ultramodern scientific management of early infancy is slowly but surely swinging back toward a more rational and normal attitude. In an atmosphere of hospital helpfulness, this new nursery design will develop in the mother more confidence in herself and a better understanding of her infant than have been possible by previous hospital practices.



SINGLE BEDROOM WITH NURSERY

BEDROOM (EACH)

1—Bed
2—Bedside stand
3—Arm chair
4—Straight chair
5—Dresser
6—Locker unit
7—Lavatory 20 by 18 inches

NURSERY (EACH)

13—Bassinet unit
15—Lavatory
17—Shelf
19—Electric hot plate

We wish to express our sincere thanks to Faulkner and Kingsbury, architects, for the forthright and practical manner in which they transferred these thoughts into hospital blueprints; to N. P. Thompson, senior architect, Hospital Unit, P.B.A., for his encouragement and endorsement of this project; to Dr. Ethel C. Dunham, U. S. Children's Bureau, Marshall Shaffer, architect, U. S. Public Health Service, and Dr. Lewis K. Sweet, chief pediatrician, Gallinger Municipal Hospital, for their many useful suggestions, and to Dr. Walter A. Bloedorn, dean of the School of Medicine, and Dr. Cloyd Heck Marvin, president of George Washington University, for the privilege of producing an unprecedented plan for the maternity division of the new George Washington University Hospital.

Four Values of Job Evaluations

CARL I. FLATH
Administrator, Charlotte Memorial Hospital, Charlotte, N. C.

MOST successful organizations in the field of commerce and industry learned long ago that intelligent job and salary evaluation "pays off" in a big way in terms of good employer-employe relations. The remainder are coming to realize under the compulsion of wage stabilization that such a program has much to recommend it.

Many commercial organizations have developed elaborate systems for classifying jobs and are constantly engaged in revising and studying job analysis methods. They consider it necessary to have a complete record of every job, its work components, the quantity and quality of output expected, the skill required, the temperament best suited to the job and other special qualifications. They have learned that the establishing of salaries or rates of pay can be done scientifically and equitably only when everything is known about the job under consideration in terms not only of its specific requirements but of its relationship to similar and dissimiliar jobs in the same company, the same industry and the same area.

What Job Evaluation Is

It is a method of analyzing jobs by breaking them down into their elements so that it is known precisely what human qualities, such as training, ability and experience, are required for it.

It is a means of comparing jobs within one organization with similar jobs in another organization and of arranging these jobs into an interrelated pattern in terms of their functional relation to one another.

What Job Evaluation Is Not

It is not an exact scientific study of jobs; it is a methodical analysis based upon careful survey and estimate of all factors that play a part in each job in the particular physical and social setting in which the job is situated.

It is not an infallible or inflexible guide in determining the worth of a job, for as each job changes because of work simplification or additional responsibilities or because of changes in any factors that affect it the importance and value of the job itself change. Interpretation of the significance of such changes and converting these into wage equivalents are important parts of personnel management.

It is not an appraisal of the worker as such. Employe rating, even though it must take job factors into account, is chiefly concerned not with the job itself but with the type of man required for it. Employe rating considers the worker's emotional, physical, social and intellectual makeup and his job behavior in relation to a particular job on which specifications have already been written as the result of job analysis. Thus, a distinction must be drawn between technics for rating the *job* and those for rating the *man*. We are dealing with the former.

Some Purposes and Values

The primary purpose of job evaluation is to establish rates of pay that will equitably compensate the degrees of skill, responsibility and other factors demanded of workers. Only in this way can wages of employes at each level be compared with wages at other levels and with wages in the same field of activity within any geographical area.

It is common practice among hospitals, when wage rates are to be set or adjusted, to circularize a number of other hospitals asking for rates of pay for jobs of the same title. As a general rule, it is discovered that rates for the same job title vary widely, even within the same community, and the hospital conducting the survey is obliged to select a rate for a particular job title which is the same as or slightly better than going rates in the area. This completely ignores the fact that duties associated with a particular job title and equipment used in the performance of the job, as well as conditions under which the work is done, may also vary widely.

It might be suggested, therefore, that rates of pay within a geographical area are only parts of an interrelated pattern and are relative unless they are adjusted to one another in terms of skill, effort and working conditions that may be imposed upon or required of the workers in each job. The following considerations should be taken into account in any salary survey:

1. Is the job the same from the point of view of work load?
2. Are the hours and working conditions similar?
3. Does training enter into the scene in both situations so that within the same induction period workers will reach standard work efficiency with a parallel increase in compensation?
4. What factors, such as maximum wages, job security and employe benefits, enter into the jobs under comparison?

A second value of job evaluation is that it provides a rational method of determining and adjusting wage rates. Wage disputes can never be satisfactorily settled by kicking the issue around and shadow boxing between management and the worker until some sort of compromise is reached which it is hoped will "hold them for a while." If the issue is to be settled in reality, it must be placed on a basis that will be understood and will appear fair to both management and the worker. The only known method of accomplishing this is by a thorough analysis of comparable jobs and by reducing them to common denominators.

No job has an intrinsic worth of its own; its value is determined by its relation to other jobs; it must be compared to them in terms of common elements. To establish relationship between these elements, point values can be assigned to each. For example, if the existing rate for a given job within a classification is acknowledgedly fair, this job can be broken down into elements to which point values can be assigned in such a way that the job can be translated into a scale of values, which, in turn, lend themselves to conversion into

Job and salary evaluations are one secret of industry's success in improving relations between labor and management

cash equivalents. This job then becomes the yardstick for other jobs within the general classification.

A third value of job evaluation is that it is the one way of standardizing pay for dissimilar jobs within an organization and of eliminating prime causes of discord which result from assumed inequalities of pay for equally difficult work. The office worker is envied because of the apparent ease of her job; the supervisor is criticized because her job seems to demand little physical effort; the administrator is criticized because of his apparent freedom of movement.

If the relative importance of these jobs is to be appreciated, the factors that contribute to the worth of each must be known; the demand for physical exertion on the part of the unskilled worker must be measured against the demand for sound judgment on the part of one in an executive position. The unpleasant characteristics of an orderly's job must be stacked against the long-broken shifts of the kitchen employe.

Must Find Common Basis

It is only when we find some common basis for comparing the worth of physical exertion, accuracy, judgment, work conditions and all other factors that enter into the worth of a job that equitable comparisons can be made. And so, by correcting inequalities (imagined or real) in job differentials and job pay by the device of job and salary evaluation, management should be able to:

1. Increase employes' confidence in its fairness in wage and salary administration and eliminate a major cause of employe dissatisfaction.

2. Show workers the incentive force of wages and salaries that are established. The knowledge that pay rates are based on the importance of duties and responsibilities and that jobs of greater importance are open to those of greater skill and ability provides an incentive for workers to analyze themselves and gives them standards and objectives in terms of promotion to more responsible assignments.

Without an evaluation of jobs and salaries management has no reliable information by which to be guided during wage negotiations on an individual or collective scale. When increases are demanded, our position has usually been based on the thesis that we have always paid this or that rate for a given job and any change will wreck us financially. There is rarely an awareness of instances when our rates may actually be out of line for like jobs in the same organization or in similar organizations in the area or where they may be grossly inappropriate for the nature and real worth of the job. These can only be known as

1. Classes of jobs in the organization are properly identified.

2. The duties, responsibilities and required qualifications of each job are known.

3. The classes of jobs are arranged in an organizational pattern that shows their relation to one another.

4. Jobs within the same class are differentiated in terms of their working conditions and opportunities.

On these factors management can remunerate labor intelligently and is in a stronger position to effect prompt and amicable adjustments when wage disputes arise.

The problem of hiring is greatly simplified when there are exact descriptions of duties, responsibilities and qualifications for each job. Applicants can be given an exact statement of what will be required of them, and the qualifications demanded by the job can be intelligently matched against the experience and ability of the candidate. Job analysis and description provide the raw data and yardsticks for such comparisons.

Finally, job evaluation will provide the necessary basis for a sound incentive system. Incentives are entering more and more into the work situation in all types of activities but if incentive standards are to be placed on an equitable basis jobs must be accurately compared and related in all respects, particularly in respect to their mental and physical demands.

In summary, job and salary evaluation provides a basis for establishing a wage or salary structure that recognizes the contribution which each job makes to the functioning of the total organization.

It provides a yardstick for estimating the worth of new positions.

It sets up wage boundaries between which employes of varying skills and degrees of efficiency may be placed.

It relates jobs to one another in terms of basic demands and provides the fundamental data for both merit rating and job training.

It does not involve the mastering of complex technics but it does put a premium on good judgment and on a capacity to get the cooperation and confidence of every person in the organization who participates in and is affected by its processes and results.

Pattern Will Be Found

It may be approached in many ways, ranging from classification by a simple listing of jobs and duties to an extremely detailed analysis of every factor of every job. Somewhere between these extremes will be a pattern to suit the requirements of most hospitals.

No attempt has been made here to describe technics. Rather it is the purpose of this article to stimulate interest in job and salary evaluating as an important part of employer-employe relations. For readers who might wish to pursue the question further, the texts and monographs listed in the footnote are suggested as basic reading. In these may be found the formula that will best fit your individual situation.

"A Case History in Wage Administration" (25 cents); "Putting Job Rating to Work" (75 cents), American Management Association, 330 West Forty-Second Street, New York, N. Y.

"Wage Setting Based on Job Analysis and Evaluation," by C. C. Balderston ($1), Industrial Relations Counselors, R.K.O. Building, Rockefeller Center, New York, N. Y.

"Manual of Job Evaluation," by Eugene Benge ($3), Harper & Brothers, 49 E. Thirty-Third Street, New York, N. Y.

"Functional Pattern Technique for Classification of Jobs," by E. W. Davis ($1.85), Teachers College, Columbia University, New York, N. Y.

"Salary Evaluation," by A. S. Knowles and T. M. McAuley (free), Northeastern University, Bureau of Business and Research, 360 Huntington Avenue, Boston, Mass.

"Job Evaluation," National Industrial Conference Board, Inc., 247 Park Avenue, New York, N. Y.

"Theory and Practice of Job Rating," by M. F. Stigers and E. G. Reed ($1.75), McGraw-Hill Publishing Co., 330 West Forty-Second Street, New York, N. Y.

"Wage Determination," by J. W. Riegel, Bureau of Industrial Relations, University of Michigan, Ann Arbor, Mich.

HOSPITAL TRAINS
Start Them Down the Road to Health

LT. COL. EDWIN N. BEERY, M.C., and MAJ. A. DONALD McLANE, M.C.
United States Army

EVACUATION operations as coordinated and supervised by the surgeon general of the Army are designed to place sick and wounded men and women of the military service returned from overseas in hospitals, near their homes, that have the proper staff and facilities for treating the various conditions.

As an example, an enlisted man who has suffered amputation of an extremity overseas is sent to one of the six general hospitals especially equipped for definitive treatment of amputation stumps, the fitting of artificial limbs and instruction in their use. The hospital selected is the one nearest to the soldier's state of residence that has a vacant bed.

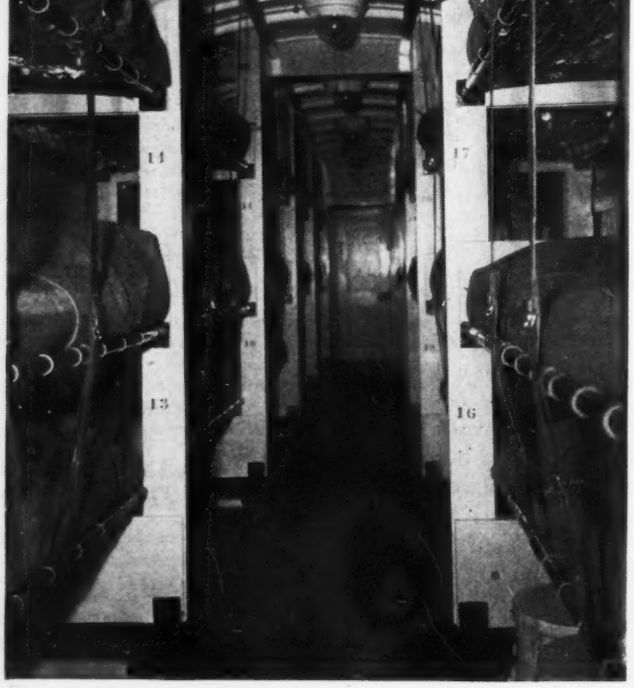
Patients returning from overseas are transported by both air and sea and upon arrival at a port of debarkation in the continental limits of the United States are admitted to a debarkation hospital at which medical care is provided on a temporary basis pending decision by the surgeon general as to the hospitals to which they will be sent for definitive treatment. Transportation from the debarkation hospital to the receiving hospital is accomplished by means of air ambulances, ordinary rail transportation or hospital trains. This manuscript concerns the last type of evacuation operation.

The Second Service Command has been operating hospital trains for more than two years and the present facilities for such operations have been in existence for more than a year. Beginning with a nucleus of six hospital cars staffed with eight officers, 12 nurses and 66 enlisted men, with no permanent base, an organization has been developed with a total personnel of more than 500, 40 hospital cars, 13 kitchen cars and a well-developed railhead having adequate facilities for storing, servicing and heating the equipment and entraining the patients. This organization has been set up as an independent service command service unit functioning directly under the service commander.

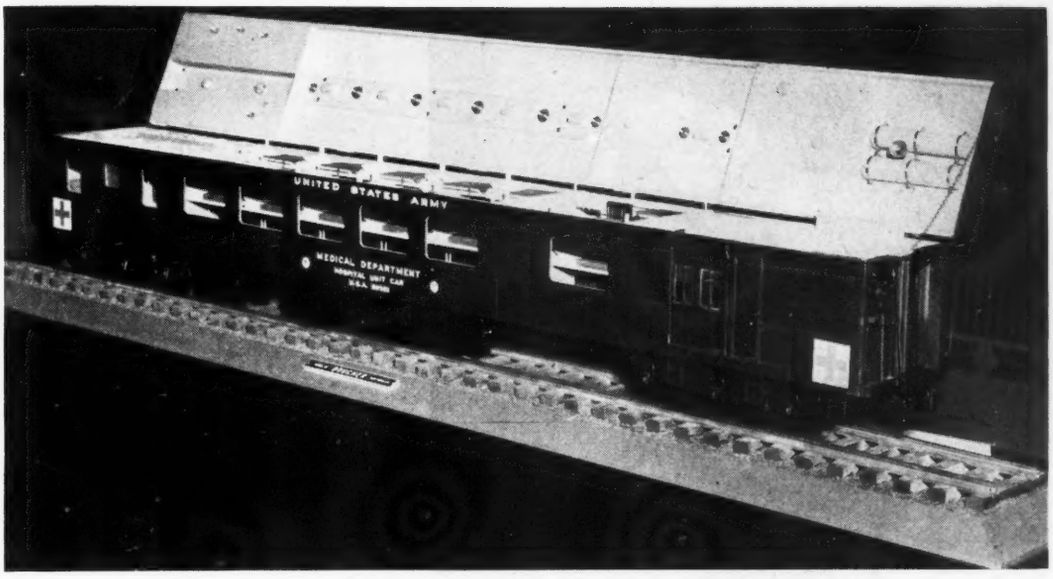
Many of the problems foreseen in the early movements of the hospital trains have been met and overcome so that at the present time patients are transported with maximum comfort, receive thorough hospital care and are fed expertly and scientifically under medical supervision from medical department kitchen cars.

After elaborate study by the surgeon general's office, a hospital train was designed and constructed several years ago for use in the United States. At that time two basic types of air-conditioned hospital cars were developed. One year ago, a modern kitchen car was developed as an adjunct to hospital trains. During the last year all hospital cars have been modified to include the addition of a kitchenette at one end of these cars. Recently, a hospital unit car has been constructed and is now in service on hospital trains. The following features are noteworthy in the construction of these various types of hospital cars.

1. Hospital ward cars have a capacity of 28. They include a kitchenette complete with a range, steam table, refrigerator, coffee urn and adequate storage space. These kitchenettes are separated from the ward portion of the hospital cars by swinging doors. It is possible to attach these cars to any regular run of a railroad after they are separated from



Interior view of a 30 bed ward car on an ambulance train in Brisbane, Queensland, Australia, showing arrangement of bunks in tiers. Photograph, courtesy Army Signal Corps.



An open model of one of the hospital unit cars designed by Boucher and constructed by the American Car and Foundry Company.

the hospital trains and they are self-sustaining in that patients can be fed from this car for forty-eight hours or more if necessary.

This utility of operation results in considerable financial savings to the government since formerly it was necessary in such instances to use either a kitchen car, which ordinarily can feed 250 patients, or a railway dining car, which for purposes of special operation required payment of a minimum of 100 meals. These cars have 14 comfortable double-deck Glennon beds attached to the wall which can be folded upward or downward so that a simulated settee can be provided during the day.

2. Hospital ward (surgical) dressing cars each have a complete operating room facility and a bed capacity of 26. These cars are identical with the hospital ward cars except that one end of the car contains a surgical dressing room, separated by swinging doors, which has an adjustable operating table, standard surgical instrument case, a kerosene-operated instrument sterilizer, cabinets with necessary supplies and a scrub sink for the medical officers and nurses.

When in use the operating table is anchored in the center of the car while at other times it is moved to one side to facilitate passage. Large reflector lights are provided to ensure adequate illumination over the operating table. As in the case of the hospital ward car, these cars include a kitchenette at one end.

3. Hospital unit cars are three tiered hospital cars with a capacity of 38 patients and attendant personnel each. At one end of the unit car are quarters for an officer and an Army nurse with complete facilities, including a shower, and sitting room when the bunks are not being utilized for sleeping.

At the opposite end of the car are sleeping facilities for six enlisted personnel or, if the occasion arises, patients can be carried at this end of the car. A kitchenette is installed at one end of the car complete in every respect for messing 60 or 70 patients. In other words, one or two Pullman tourist cars can be attached to these unit cars and the patients transported in all three cars can be fed from the kitchenette in the unit car.

At one end of this car are two large doors that open inward, together with a loading platform for the entrainment of litter cases. There are a toilet for the patients, wash basins and a service sink compartment for use by the nurse and ward attendants for cleaning and sterilizing bedpans and urinals. There are adequate storage facilities for linen, medications and other stock that is essential in the medical care of patients. Large shatterproof glass windows afford an ample view.

4. Medical department kitchen cars are manned by Army cooks under the supervision of a mess officer and mess sergeant and can provide any type of special diet. Menus are prepared and posted in these cars before departure. A minimum of 3500 calories a day is furnished to each patient on the regular diet. Adequate supplies of milk for both ulcer and other patients are maintained in the refrigerator at all times. Food is carried hot from the kitchen cars in large food containers, placed on tables in each ward car and served immediately on sectional trays to the patients. Most of the patients come back for second helpings which are always available.

Emergency nursing and medical care of all types is administered to patients. Excellent sleeping and messing facilities are provided. Recreation is under the supervision of the nurses. Games, cards, newspapers, magazines, cigarets and puzzles are distributed throughout the train by the nurses and medical department enlisted men.

Berths are assigned to each litter and ambulatory patient by the medical officer in command of the train before entrainment of the patients. The placing of each patient in his berth is supervised by a medical officer or nurse to ensure the following:

1. The most seriously ill or injured are placed closest to the nurse's desk.
2. The ailing or injured part is placed nearest to the aisle of the car.
3. The head is in the direction of travel of the train.
4. Patients with injured extremities in casts are not placed opposite to each other so that blocking the aisle of the car is avoided.
5. Those demanding the most nursing care are placed in lower berths.
6. Communicable or infectious

One of the most important parts of any hospital train is the mess section. Plenty of fresh fruits, vegetables, milk and butter, as well as meat and fowl, are provided in the well-balanced meals served to the men. Official U. S. Army Hospital photograph.

cases are placed at one end of the car and are segregated completely by a drop sheet.

Immediately upon the transfer of each patient from his litter to the ward car berth, the nurse covers him with a sheet and blanket and, if necessary, places a headboard at the head of the berth. When entrainment of a car has been completed, the nurse begins the ward car census report which records the berth assigned to each patient and indicates the type of case, whether medical or surgical; the Army serial number; mobility, that is, fully or partially ambulatory or litter, and the type of diet. This information is transmitted promptly to the train commander who consults the mess officer and directs the preparation of the necessary special diets in the medical department kitchen car.

Administration of a hospital train en route is similar to that of a fixed hospital. Both nurses and medical department enlisted personnel serving as ward attendants are assigned to duty day and night. Members of the enlisted personnel have been specially trained in medical and surgical nursing and are capable of substituting for and performing all of the essential duties of nurses when necessary. These men can administer all types of medication, including hypodermic injections, and are trained to note changes in the physical status of their patients. They are at all times under the supervision of a medical department officer or an Army nurse.

Routine nursing care, similar to that provided in any hospital, is given to all patients. It includes a sponge bath, cleansing of teeth and remaking of beds at night. On awakening in the morning each patient is again bathed, teeth and mouth are cleaned, toilet is attended to and, if necessary, fresh linen is placed on the bed. After breakfast, the nurses distribute magazines and books. A phonograph is available in each car to add to the morale of the patients when their condition permits its use.

Temperature, pulse and respiration are routinely taken three times a day on all litter cases and any other patient where indicated. The nurse and enlisted men assist litter patients at mealtime.

To facilitate bathing of patients in upper berths and to avoid spilling of water, alcohol or other liquids, a specially designed portable washstand is used by the nurses. This stand fits to the side of the Glennon bunk by curved hooks. Its cavities hold snugly a water basin, an alcohol bottle and a powder can. On each end of the washstand is a small metal holder for towel and cloth.

The responsible medical officer makes rounds immediately after all patients are loaded, and frequently thereafter throughout the day. Every patient is looked at and those requiring special attention are seen as frequently as necessary. A nurse records all orders relating to the care and treatment of all of the patients in the cars.

Hospital ward cars are equipped with all types of medications and facilities for special treatment, such as irrigations and administration of insulin, liver, quinine, atabrine and sulfa drugs when indicated.

A complete record is made of all treatments given to patients en route, as well as of the comments, attitudes and opinions of the patients as to their care by the duty personnel and the quality of mess. Effort is constantly made to improve the quality of professional care.

Final night rounds by the ward medical officer, accompanied by the nurse, are made each evening, when, except in unusual cases, the final medications for the day are administered. The patients are then prepared for the night by the nurse and ward attendants. All lights other than the aisle lights are out at 9:15 p.m., and, as the hospital trains roll through the night, sleep is assured for all aboard except for the duty personnel.

In the Second Service Command all hospital train activities are under the immediate staff control and supervision of the service command surgeon. Trains are made up in a special section of the surgeon's office, based on the destination as supplied by the surgeon general in Washington, D. C.; personnel and equipment as recommended by the train unit commander, and traffic routings and clearances as furnished by the chief of transportation in Washington, D. C.

Instructions to the hospital train unit and the various hospitals are coordinated and cleared through this section of the surgeon's office. Upon completion of each trip, the movements, operation and messing reports are studied there with the purpose of improving all of the various actions involved in entrainment, medical care en route and detrainment at destination.

The Purchasing Agent Selects a Salesman

WALTER N. LACY
Purchasing Agent
St. Luke's Hospital
Cleveland

SIT in a purchasing agent's office and watch the procession of salesmen who come and go. They are tall and thin, short and stocky, blond or brunet, natty or sloppy, dignified or breezy; they may hang their hats on the unsigned letters on the desk; they may ask for permission to clean the institution; they may have news from a mutual friend or acquaintance that makes a good "opener"; they may have just dropped in to say "hello."

As the door closes behind the last of the day's callers, you ask "If you were looking for a salesman, which of all these would you pick?" The purchasing agent's choice was for THE MAN WHO:

Introduced himself. Every purchasing agent is not fortunate enough to recognize and name every salesman who calls on him two or three times a year. The caller has looked at his card at the hospital entrance and so is expecting to find Mr. X at the purchasing desk. Hence, he comes in saying, "Good-morning, Mr. X; you remember me?"

One purchasing agent tells of an Anonymous Andrew who called on him "for six years without divulging his identity and what he sold." The buyer will, of course, soon know the frequent caller; the occasional and infrequent caller should not presume the hospital buyer will recognze him when he has never recognized the buyer on a downtown street.

Respected the salesmen's hours. Regardless of one's personal views as to whether a hospital buyer should or should not have certain hours for seeing salesmen, if he does, the salesman should try to observe them. Of course, there is the new man in the territory or the one who has never called on this purchasing agent before, and there is the out-of-town salesman who may not be able to be in the city at the right time. But to say "I happened to be in the vicinity" or "I lost your card" may get the salesman an entrance—with the wish that he hadn't come then. If a buyer has "salesmen's hours" he has a reason for it: it's a time ration plan to help them all. Why should they seek a "black market"?

Had samples or suggestions. The salesman who calls or telephones "Have you anything on your list today" may or may not get an order. "Off the bat" you may not think of everything he could sell you. The one who has samples of towels that are evidently a good buy, who has a list of jellies or pickles that he can supply, who can tell you of a new deodorant on the market or a special offer on aspirin tablets may make a sale: one that wasn't needed enough for the purchasing agent to initiate an order but one that he recognized as a worth-while purchase for his institution. And it often reminds him of something he really does need.

Left his competitor out of the picture. The purchasing agent does not like to be told that what he is buying from another company is inferior; perhaps he knows it or perhaps it isn't. The purchasing agent does not need to be told what he is paying for a competitor's product; he will probably know whether the item now offered is less expensive, if it is. The purchasing agent may not believe all he is told about a competitor's faults and failures—perhaps he shouldn't. This salesman may be selling for that competitor the next time he calls—it has been done.

Recognized that the purchasing agent was an intelligent being. Is it the salesman's prerogative to tell the purchasing agent how to conduct his business or what his institution needs? After all, the purchasing agent probably knows his hospital and the desires of its several departments better than the salesman who calls occasionally; if he doesn't his superintendent and not a salesman is the one to set him right. If he has tested this or similar products his results are probably not worthless. At any rate he is not likely to be as biased as the salesman.

Took orders from the purchasing department only. He recognized that the institution had a purchasing agent for good and sufficient reasons. He had not wheedled a requisition from some department head and then expected to find a rubber stamp in the purchasing office. He had not considered an expression of interest by some department head as an order and thereupon made a shipment which was not wanted and which the hospital had to refuse. He asked permission to discuss and demonstrate his product for the information of the person he thought would be interested and then he recognized the buyer's judgment in granting or refusing that permission.

Made only statements that he could back up. When he didn't know when delivery could be made, he said so. Had he promised a specific delivery date, without reasonable assurance of its fulfillment, and then failed, the purchasing agent could well have been embarrassed, perhaps seriously handicapped. Nor did he offer for sale something that twice previously he had said would not again be available and now said, "when these are gone there will be no more." By this time the P. A. was willing to take the chance.

Had something to sell which he tried to sell on its merits. He did not stress his company's contribution to the Community Chest or the educational campaign his company was offering to schools of nursing. He did not try to sell on the strength of other hospitals that had bought his product, carefully overlooking any mention of those that had refused it

or had never placed a repeat order. He had something that he felt it worth while for this institution to use, he offered a price that was final and that he thought it merited and he was willing for the purchasing agent to try it for himself without any "return-it-and-get-your-money-back" proposition.

Had terminal facilities. He told his story and he took the buyer's decision. There was no repetition of argument, no insistence on a trial or a larger order. He knew how to bring his call to a close gracefully without hanging on when he should have recognized that his welcome was worn out. He had not confined himself too strictly to his merchandise (that is not expected) but he had not wasted a lot of time on extraneous topics. He did not seem to be groping for an excuse to get away but knew when and how to leave.

Was a likable caller. He was courteous without being familiar, he was intelligent without being bombastic, he had convictions without being dogmatic, he had opinions without being a mirror. He was cultured, cordial and friendly and, in every sense of the word, a gentleman.

In other words he was a man whose call was a pleasant spot in the day. He would be welcome the next time he called.

Long-Term Illness

Must Be Fought on Two Fronts

EDNA NICHOLSON
Director, The Central Service for the Chronically Ill, Chicago

WE ARE rapidly moving out of the era when nothing was being done about caring for the chronically ill. We have not yet, however, entered a period when well-planned and effective action is assured. In the meantime, failure to meet the need intelligently not only results in lack of good resources but serves to foster the development of poor ones.

There is a direct relationship between our failure to keep pace with the growing need for good facilities for care of our long-term sick and disabled patients and the rapidly increasing numbers of low quality proprietary boarding and nursing homes and only partly converted almshouses that are springing up all around us.

Reliable estimates indicate that there are at least 23,000,000 persons in the United States suffering from long-term illness and that about 1,500,000 of them are complete invalids. Many of these patients need diagnostic and treatment services that can be provided only in a well-equipped hospital and many need only services that can be made available in the home.

Of the latter group a majority have families and homes of their own in which they can be cared for and in which they prefer to stay. A significant number of them, however, probably about a third, either have no families or do not have homes in which satisfactory arrangements can be made for their care.

For those patients who can profit from specialized diagnostic and treatment services additional hospital facilities are urgently needed. For those who need only services that can be provided in the home but have no homes of their own in which the necessary arrangements can be made, good substitute homes must be developed.

One of the most tragic aspects of long-term illness is the extent to which patients are now being consigned to lives of invalidism without adequate clinical study and sufficient attempts at treatment to justify the decision that no effort will be made to treat them. It is undoubtedly true that medical science cannot cure all of these patients. It is equally true, however, that medical science is steadily advancing and that the case which seemed hopeless yesterday may be cured or greatly relieved through new treatment methods tomorrow.

It is also true that, because we do not have enough treatment facilities available, patients are being turned over to "custodial institutions" with little or no effort at treatment, although if it could have been tried the treatment might have resulted in partial or complete restoration of function or, at least, in significant relief from suffering.

The time has come, I believe, when the custodial institution should be completely eliminated from both our thinking and our practice. Patients suffering from long-term illness do not, for that reason alone, need to be taken into custody and should not be brushed aside or herded into custodial institutions merely because, in addition to the pain and suffering of their illness, they bear the burden of hopelessness for recovery.

If we are to have any hope of remedying the inadequacies in the care of our invalids which are troubling us so deeply today, we must adopt a much more positive attitude than we have shown in the past toward the needs of these patients who may not be able to profit from hospital treatment but who do have definite needs of other kinds.

The facilities for care of people suffering from long-term illness needed most urgently in our com-

munities at the present time fall into two general classifications: hospitals and homes. In one sense, the needs of the chronically ill do not differ from the needs of any other large group of people. They need homes to live in and hospitals to which they can go for specialized study or treatment, returning to their homes when the specialized service is no longer needed, going back to the hospital when it again becomes necessary and again returning home when the need has subsided.

It is true that the patient suffering from long-term illness may need to remain in the hospital for more extended periods of treatment than does the average acutely ill patient. It is also true that provision may have to be made in the home for personal attention and nursing which are not required by the well person. This does not mean, however, that no patients should go to the hospital unless they can be expected to recover and be discharged within a two week period or that all patients who need personal care or nursing should be hospitalized.

Hospitals and Homes Both Needed

Much of our present confusion regarding responsibility for meeting the problems of the chronically ill may be due to the fact that we have not fully recognized the need for the two quite different kinds of care and the way in which they supplement each other.

It is not a question of whether the need is for hospitals or for homes. Both are needed. Neither can substitute for the other and neither can fulfill its function satisfactorily unless it is supplemented by the services of the other. No one interested in the welfare of either patients or hospitals wants to see the hospital turned into a home for the infirm or a boarding house for the handicapped. Neither do we want to see homes and boarding houses turned into second-rate hospitals. Something very like this is happening all around us at the present time, however.

If we are to avoid it we must develop a clearer recognition of the supplementary, but distinct and different, functions of homes and hospitals in meeting the needs of chronically sick and disabled people. They must be developed concurrently and their services must be so coordinated as to permit prompt transfer of the patient from home to hospital and back to the home as changes in his condition occur.

Substitute homes may be found in privately operated nursing homes, in informal "foster home" arrangements for individual patients, in institutional services similar to our present homes for the aged or in facilities such as are now offered in our ill-named, but quite often well-operated, "homes for incurables."

For purposes of planning adequate community services for chronically sick patients, however, it seems important that the character of these institutions be clearly understood as homes and that they stand alongside the patient's own homes in their relationships to hospitals.

The functions of these homes should be to offer the best possible substitute for the individual family home, in which the personal attention and nursing are provided in as informal an atmosphere as possible and with as much attention to the individual differences of the patients as can be provided. Their purpose should not be confused with that of the hospital whose prime objective should remain as it now is: the provision of specialized facilities for diagnosis and treatment.

Estimates indicate that the combined need for beds for long-term patients in homes and hospitals is probably about equal to the total number of beds now provided in all of our acute general hospitals combined. This is in addition to the number of beds already available in tuberculosis and mental disease hospitals, and in addition to those occupied by patients in their own homes.

In 1940 Boas in his book, "The Unseen Plague—Chronic Disease," estimated that roughly 60 to 75 per cent of the total number of patients were in need of homes as distinguished from hospitals. Bluestone has indicated his belief that the proportion of patients who should have hospital treatment is higher.

There can be little doubt that, in addition to patients who can profit from treatment, there is a great need for hospitalization for thorough clinical study upon which to base the decision as to whether treatment could offer help for the patient or attempts at treatment should be abandoned and the patient sent home. It is also true that, as medical science progresses, patients who would have been considered hopeless are moving over into the group for which treatment can offer at least some restoration of function, if not a complete cure.

Perhaps, in one sense, it is not of great immediate importance whether more or less than half of the additional beds needed for care of long-term patients fall in the hospital services as distinguished from the need for homes. At the present stage of our planning and development the unmet need in both groups is so great that all possible efforts at expansion of both types of facilities cannot be expected to meet the need for many years to come.

First Step: Recognizing Need

Recognizing the need for new facilities and identifying the kinds of facilities needed are, of course, the first steps toward obtaining them. Once this has been done, however, the next question becomes one of methods for developing and financing them. Obviously, the need for additional facilities is so great that it cannot be absorbed by existing institutions.

It is not merely a matter of hospitals or homes for the aged or any other institutions or agencies deciding to change their policies or be more flexible in their admitting procedures. It is a matter of extending services, providing more building space, obtaining staff, providing for additional financing and carrying on conscious planning to meet broader responsibilities.

Our communities must face the fact that greatly extended services are needed for adequate care of our long-term patients and must be prepared to furnish the leadership and financing that can bring them into reality. There are many indications that communities all over the United States are facing this fact and it is interesting to note the extent to which many communities are being held back in the development of new facilities not by lack of community interest and financial support so much as by lack of practical knowledge on how to proceed.

This is especially true on such points as specifically what is needed, how much, what it should cost, who should sponsor it and where it should be located. Much thinking remains to be done on such points

as how much responsibility should be carried by government and how much by voluntary philanthropy for developing and operating the additional services that are needed. How much of the load should be left to proprietary services, particularly the privately operated nursing homes?

To what extent does the fact that tax funds are needed to help finance the care of many patients necessitate the operation by government of the institutions providing the care? What, precisely, are the relative merits, if any, of specialized hospitals as distinguished from specialized wards and services within the general hospital? What are the desirable size and location for hospital facilities? What are the best methods for assuring coordination of service between homes and hospitals?

These and many other practical questions need full, critical consideration in every community, and they need it immediately. We cannot hope to have sound community services without careful thought and effective planning, and we cannot afford to delay any longer in clarifying these plans and translating them into reality.

Money Is Available

Questions remain to be answered also in relation to financing for the additional services needed. The patients are here. They must have—and are having—care somewhere. Much of it is entirely inadequate but it is the best available and significant amounts of money are being spent every day to pay for it. A great deal of this money can promptly be diverted to pay for the care of the patients in better facilities as rapidly as such facilities can be made available.

It may be that too much stress has been placed upon the extent to which the problems concentrate in the lower economic groups. Actually, the need for care, in both hospitals and homes, is by no means limited to the destitute. As many writers have pointed out, illness contributes heavily to poverty. It strikes more often in the low income groups and, having struck in the middle income groups, it tends to push the family down into the lower economic level both by cutting off income and by increasing the expenses. Illness is no respecter of persons, however, and significant numbers of patients in need of care are able to, and wish to, pay a part or all of the costs of the care. Of 758 requests for help in locating care for chronically sick patients handled in recent months by the Central Service for the Chronically Ill in Chicago, 711, or 94 per cent, involved financially independent families prepared to pay part or all of the costs of the patient's care.

How much this financial picture will change when the present economic stresses are relieved is difficult to estimate. Undoubtedly, there will be a decrease in the ability of families to pay for care. It is equally certain, however, that there will remain significant numbers of families that expect and want to pay at least a part of the costs.

Literally millions of dollars are now being spent for the care of the chronically ill and there is every reason to believe that much of this money is only waiting for the development of good facilities to be diverted from its present uses and channeled into the support of improved services.

A second point on which confusion frequently exists relates to the operation of services under governmental auspices as distinguished from voluntary philanthropy. It seems frequently to be assumed that because funds to pay for care of patients must, to a significant extent, be supplied by taxes, the institutions providing the care must be operated by government. The fact that significant numbers of chronically ill patients are not able to meet the costs of their care does not necessarily mean that they may not have care in the same institutions as do other patients in the community.

It is true that for many years we proceeded on the assumption that the poor could not be trusted to handle money and that if help was needed food, clothing, fuel and other necessities should be provided "in kind" and medical care should be supplied by county doctors and county hospitals. Working on this approach we are still operating county infirmaries and county hospitals offering "free care" to the poor.

Government, in this way, not only meets the costs of care for the poor but also operates a special institution to provide it. In most instances, the services of the institution are available only for the poor, with the result that the poor are segregated for care in special institutions, to which patients frequently are reluctant to go because of the real or imagined stigma of pauperism and because of fear of low standards of care.

In more recent times, however, new philosophies regarding financial assistance to the poor have emerged. The Social Security Act, with its provisions that assistance funds may be used only for cash payments to the recipient, gave widespread impetus to the growing use of cash assistance in public welfare and relief programs.

We Have a New Philosophy

Large amounts of tax funds are now being used to pay for the care of financially dependent people in hospitals and other services operated by voluntary philanthropy or under proprietary auspices. It is probable that more than half of the chronically sick and disabled patients whose care is now being financed by tax funds fall into this group as opposed to the group whose care is supplied "in kind" in tax-supported city or county hospitals and infirmaries.

This method of meeting the costs of care for patients not able to finance it for themselves not only is more acceptable to the patient but has the further advantage of permitting greater flexibility in the use of facilities. Under such a plan the necessary facilities are available to all who need their services without artificial economic barriers.

In any event, there is a definite trend toward integrating services to financially dependent people into the established community services and more questions are being raised as to the advisability of operating separate institutions whose services are limited to the poor.

We need more facilities for the care of all our chronically sick and disabled patients and there is every reason to believe that if any satisfactory and practical solution is to be found for the problem it will be made up in substantial part of services provided by voluntary institutions and, to some extent, by proprietary services. It is to be hoped that the immediate future will see increasing services for these patients developed under voluntary, not-for-profit auspices.

PREPARATION Spells Success *for the* Public Relations Program

ELEANOR BARNES
Director
Public Relations
Memorial Hospital
New York City

THIS article concerns itself with the voluntary hospital that gives less-than-cost care to part of its community, which therefore has a legitimate claim upon the other part for support and proposes to get it by means of a public relations program.

Suggestions for preparing for such a public relations program are predicated upon this definition:

> "The purpose of a voluntary hospital public relations program is to interpret the needs of the community to the administration of the hospital and, in turn, to interpret the services, facilities, policies and needs of the hospital to its community in such a way as to create moral support which the public relations office can convert into financial support."

Articles in previous numbers of The MODERN HOSPITAL have emphasized as the first prerequisite for an effective public relations program a hospital service that will bear inspection—a hospital whose house is in order and that is meeting the needs of its community. This should be self-evident. In fact, "public relations begins at home" has been said so often as to have become a cliché. What is not always understood is that it means every hospital and not just the other fellow's.

It Won't Whitewash Mistakes

Some hospitals, realizing the need for increasing good will toward their services, instead of improving these services are inclined to seize upon the idea that a public relations program can do a good job of whitewashing and setting everything straight with the public. Of course, if perfection were a prerequisite, we should have no public relations programs—and no need for them. If, however, a hospital with a fairly high batting average displays a will to correct its inadequacies, the community is pretty likely to accept its good intentions as advance payment on what it owes the community. And support will be forthcoming.

In some large communities, a formal survey of community attitudes may be advisable before undertaking a public relations program. However, in the average community the hospital through the years has become aware of the nature of public opinion and of the extent of support possibilities. In any case, community attitudes should be appraised and the results should be set down on paper and faced frankly. This will give a sense of direction in formulating a public relations program and will indicate where first emphasis should be placed.

The need for a public relations program is likely to spring from the mind of the administrator, who is vitally concerned with two-way traffic in public attitudes, not to mention his interest in the little matter of meeting his operating loss. The greater the need for support and good will, the greater the interest and enthusiasm of the administrator and the board of trustees are likely to be, and the stronger their determination to conduct an effective public relations program.

Such an effective program will have to involve not only the administrator and the board and a staff public relations executive, but also the medical board, the volunteers, every doctor and nurse and every lay and professional worker.

With these prerequisites in mind, a step-by-step plan for launching the program may be considered.

First of all, the administrator and the president of the board should agree on the need for an organized public relations effort. They should then confer with a special preliminary committee of board members, chosen by the president for their probable interest and aptitude, and formulate a preliminary plan for presentation to the entire board.

This preliminary plan should cover the following points:

1. Why a public relations program is needed. This should include an analysis of community attitudes and a statement of the financial needs of the hospital.
2. What the objectives of a public relations program should be, both tangible and intangible.
3. Tentative estimate of the cost of the first year's program, detailed budget to be drawn up after the program is outlined. The tentative figure might be set arbitrarily at a maximum of 2 per cent of the estimated operating expense.

Trustees Must Be "Sold"

The preliminary plan should be thoroughly sold to the board to the point of active interest, not merely passive acceptance. This is vitally important, as board interest and understanding form the foundation upon which the whole public relations structure rests, and the entire success of the program must depend upon the unanimous approval of the board. If there is indifference or skepticism or opposition at this point, the weakness will be bound to show up later when the public relations program gets under way—*if* it gets under way.

Once the board has wholeheartedly endorsed the general idea, it should authorize the preliminary

committee to engage a public relations executive.

In a well-rounded public relations program, the executive will have to be responsible for the following six major functions, and he should therefore, ideally, have experience and aptitude in all of them:

1. *Fund Raising.* Mail appeal, personal solicitation, group activities, benefits.
2. *Press and Radio Publicity.*
3. *Printed Promotional Material.* Leaflets, annual reports, periodic bulletins.
4. *Meetings and Social Events.* Annual meetings for the public, open house, public health lectures, teas and dinners.
5. *Committee Organization and Direction.*
6. *Office Routine.* Planning and supervising: list building, contribution records, reports.

It is vitally important that the public relations executive should be acceptable to the board and the administration, and that he should have their complete confidence from the start.

Engage Executive First

A standing public relations committee should not be appointed until after the executive is engaged. An experienced executive will be in a better position to suggest the type of committee than an inexperienced committee would be to suggest the type of executive.

It may be advisable in some circumstances, however, to appoint a public relations chairman before engaging the executive.

The ideal chairman would be an outstanding man with business and social prestige—one with an understanding of public relations—and, above all, with *a will to do the job.* It should be his major hospital job, preferably his only hospital job. "No man can serve two masters" is signally true in public relations work. It is so much easier for most board members to be so interested in such concrete problems as employe wages or plant repairs that they would be likely to let public relations become secondary if they undertook any other responsibility.

A man who has had experience in practicing public relations in business, not necessarily as such, would be better than an "ideas man" from the advertising or publicity field who is often thought of for the post. Such a man, however, might well serve on the public relations committee as adviser on the press and radio publicity and exhibits. A vigorous executive of a successful business, either active or retired, might be the ideal selection for the chairmanship, provided he had the personality, the prestige and the leadership.

With a competent executive, the chairman's job should not be too time-consuming, although he should be available for a reasonable amount of consultation at his convenience; and he should, of course, have time enough to keep informed of all public relations activities. The job should never be irksome to him. Public relations can be fun! And no one should be permitted to work at it who doesn't believe that.

The chairman of the public relations committee should, of course, be a board member and he should also be a member of the executive committee. This not only attaches the proper prestige to the public relations function, but it serves another practical purpose as well. There is no phase of hospital operation in which public relations is not involved, and the chairman should have an opportunity to participate in all the vital and confidential discussions of the executive committee or "inner circle" of the organization.

Other members of the public relations committee should be chosen to supplement one another, perhaps to head special functions for which they are especially fitted or to represent various geographic sections served by the hospital. In any case, each member should be selected for some specific purpose which can contribute to the success of the program.

The first responsibility of the public relations executive should be to work out a detailed program for presentation to the board and a more realistic budget than was presented for preliminary consideration. While this material should first have the approval of the public relations committee, the executive should present it because he will be in a better position to answer questions and to make explanations of a program which he has devised and for which he will be responsible.

After the program has been officially approved by the board, a period of at least two months will be necessary to prepare for the initial approach to the public. During this period of preparation, the whole public relations plan should be thoroughly sold to the hospital organization and the working machinery should be set up. These two major functions can proceed simultaneously.

With the cooperation of the administrator, the chairman and perhaps the president of the board, the executive should describe the proposed public relations program to the medical board, the entire group of doctors, the nurses, lay staff, volunteers and auxiliaries, with questions and discussion encouraged.

The program should be presented as an integral part of the hospital's service. All too often, it is considered the fifth wheel to the coach—a sort of step-child—or perhaps a plaything of the board that must be accepted with amused tolerance or with resentment, or as a catch-all department for odd chores.

Hospital staffs, overworked and with vital direct services to patients to perform, usually have difficulty in understanding or accepting the indirect but vital function of public relations, especially when it is new. At this point, of course, the personal understanding and backing of the administration and the chairman are most important.

Good Lists Are Essential

Alden Mills, in his book, "Hospital Public Relations," says that if he had a dollar to spend on public relations, he would allot 25 cents to lists. This may be realistic and it may be arbitrary. The cost of a good list depends upon many factors. But it must be good and building and maintaining it is almost a profession in itself. It might well include as a nucleus all persons known to have contributed to the hospital for any purpose; relatives or descendants of founders, early board members or early doctors; present doctors; contributors to other local philanthropies; country club and civic club lists, and, in some communities, the telephone book classified by streets. It is inadvisable to use lists of patients as such. If they are potential givers, their names will crop up on some other list.

There should be a list committee or an individual on the public relations committee responsible and constantly on the alert for good new

names, especially newcomers to the community.

A certain amount of printed matter should be prepared before opening up shop. A minimum would include stationery listing the names of the board members, printed return envelopes, subscription blanks, a general information leaflet and, of course, official receipt forms. The hospital auditors will probably insist upon serially numbered receipts in triplicate; the original copy for the contributor will be most effective if it is printed on safety paper.

In inaugurating a public relations program, another "must" in obtaining proper prestige for the new work, which is likely to seem unimportant, is adequate and appropriate office facilities. Because a new public relations department is difficult for hospital personnel to grasp, the space allotted to the public relations office may be an indication to them of the relative importance attached to the new venture by the administration.

The public relations executive should have a private office. Many confidential matters will be discussed there—much steam will be let off. There should also be appropriate and adequate working space with facilities for checking lists, filing and storing printed matter. The recommendations of an experienced executive should be heeded on these points.

There should be some provision for simple hospitality. It should be possible for the public relations committee to entertain at luncheon or tea certain key people in the community or prospects for special gifts who wish to visit the hospital. It can be done at nominal expense and has been proved of great value.

If all these preliminary steps are effectively taken, the public relations executive, with the full backing of the board, the public relations committee and the administration should be able to start out under auspicious circumstances to conduct the approved program. There will be a certain amount of interpretation of his work which he will always have to do, but he should not be handicapped by being constantly called upon to justify the need for his work. He will need all his energy and enthusiasm and courage for his job. It will be a tough assignment at best.

Nursery School
Enriches pediatric training

SISTER FIDELIS
Director, School of Nursing
Allegany Hospital, Cumberland, Md.

THE Keating Memorial Day Nursery offered a splendid opportunity for the Allegany Hospital School of Nursing, Cumberland, Md., to expand its pediatric facilities and to enrich the experience of its student nurses.

With the increased student enrollment and participation in the U. S. Cadet Nurse Corps program something had to be done to strengthen our weakest service. While we knew the opportunities for studying the well child would be most beneficial to the nurses, we little realized the wealth of opportunities in this particular nursery school.

The Keating Memorial Day Nursery is conducted by the Daughters of Charity of St. Vincent de Paul and is governed by an advisory board of lay members, including a pediatrician, two other physicians, a lawyer and representatives of various civic organizations. It was inspected and approved by the state of Maryland. Located in the central part of Cumberland, the nursery school is in a convenient place for the mothers to bring their little ones on their way to work.

The nursery school capacity is 30 children from 2 to 6 years of age. It is staffed with a director, one assistant teacher and the student nurse. It is supplied with a housekeeper, cook and janitor. Dietary consultation is available through Allegany Hospital. The student nurses' activities are subject to the supervision of the director of nurses, who in addition to being a registered nurse is also a trained play leader.

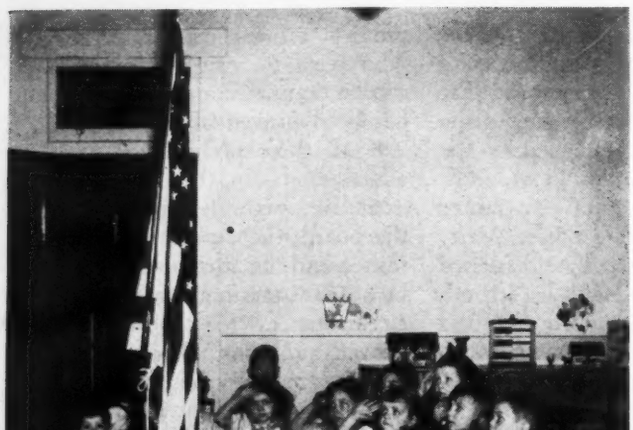
The nursery school comprises two playrooms furnished attractively with everything that appeals to the young child, such as linoleum rugs in patterns depicting the characters in nursery rhymes, pictures, small tables and chairs, rhythm band instruments, a piano, electric phonograph and radio with nursery rhymes, children's songs and march records, blackboard and many and varied educational toys and games for free and organized play.

In a spacious dining room having miniature tables and chairs and tablecloths of varied patterns to harmonize with the pastel tints of children's dishes, the nourishing, well-prepared meals and lunches are served. In miniature lavatories each child finds his towel, comb and toothbrush by some special identification, such as a fruit, vegetable or flower.

The rest period is spent in a large well-ventilated room where the wall cots invite each little occupant to the land of slumber. All the children are protected by a seldom used isolation nursery. In this attractive room the little tot does not mind spending the few hours between the appearance of the first symptoms and the time the mother takes him home.

Last, but most important, is the little chapel where the Sisters receive the spiritual assistance to enable them to carry on their noble work. The children, too, ask to go to God's house to speak to Him and tell Him they love Him or to pray for Daddy to come back safely from overseas.

Out of doors, the nursery school lawns and recreation grounds furnished with a castle tower, rocking boat, swings, see-saw, scooters, tricycles, wagons, doll carriages and



In addition to caring for the physical needs of the youngsters, the student learns to consider the spiritual, social and emotional development of the well child and relate her training to the care of the sick child.

sand boxes provide an outlet for these happy healthful children.

The daily routine is as follows:

Morning

8:30—Health inspection
8:55—Rest. Music appreciation
9:00—Supervised quiet play
Singing
Rhythm band
Free rhythm
9:20—Supervised active play
Dramatization by means of stories and poems
Language drill by means of conversation
9:40—Spontaneous active play
10:40—Lavatory. Wash hands
11:15—Rest. Music appreciation
11:25—Prayers
11:30—Dinner

Afternoon

12:15—Lavatory. Wash hands
12:30—Afternoon nap
2:30—Lavatory. Wash hands
2:45—Lunch
3:15—Spontaneous active play
3:45—Supervised quiet play
Creative skills, painting, drawing, molding clay
Art appreciation
4:15—Clean up, put materials away
4:30—Conversation period
Supervised quiet play
Picture books
Beads
5:00—Preparation for home
Lavatory. Wash hands

Interspersed in this routine are special occasions on which activities are planned according to seasons and holidays. Parents of the children, members of the nursery school board and representatives of various civic organizations are invited to the nursery and the children are delighted to prepare special programs and display their talents before their loved ones and those who are interested in them. The parent-teacher relationship is excellent.

Since the war began, as a special reward for good conduct, five or six children are daily allowed the privilege of going to the chapel to say a little prayer for peace.

A physical examination plus immunization vaccines is required for entrance. Any child absent for two weeks must present a certificate from a physician before returning to the nursery school. Recently, the health program was enlarged to include a routine Wassermann for admission. This service is afforded through the Allegany Hospital.

To summarize, the student nurses, in general, learn to consider the following points during their two weeks of nursery school experience:

1. The total well-being—spiritual, physical, mental, social and emotional—of the child in health.

2. That they should see Christ in the person of the well children as they do in their little sick patients. To remember His words, "Suffer the little children to come unto Me and forbid them not for of such is the Kingdom of Heaven."

3. That children in an informal way learn about God and His wonderful gifts from the things they use and see each day. They learn to thank Him for gifts by saying their prayers before and after meals.

4. The economic, cultural and emotional background of the child; the parent-child relationship.

5. That the nursery school provides a more formal education in behavior approved by society. Early training in self-control and adjustment and in solving problems is a basis for developing the well-integrated personality of the adult.

6. The importance of observing details in health inspection and of correcting faulty habits.

7. The effects on the child of healthy environment, a nourishing well-balanced diet, organized play, rest and proper elimination.

8. The stages at which the child is taught to increase his personal services for himself and render himself less dependent on others.

9. How bad habits, the result of faulty home training, can be overcome gradually by substitution.

10. How selfish children learn to become interested in rendering service to others.

11. How personal hygiene is made attractive for little ones.

12. That there are wide individual differences in children and that they must be treated accordingly.

13. To appreciate and understand better their sick children in the hospital from their knowledge of the well child and the factors which make for his total well-being.

The student nurse returns to the pediatrics department after her two weeks' nursery school experience with the knowledge of what her sick little patient should be like, of the factors that may have caused his illness or retarded his convalescence and the great difference between the sick and the well child. She becomes more interested in occupational and recreational therapy for her sick children in their convalescent stage, more desirous of being a health teacher and influencing parents to do the things most conducive to making sick children like the healthy happy children she loved and helped at the day nursery.

Introducing the Rehabilitation Director

ALBERT LASKY
Assistant Director, Montefiore Hospital, New York City

PROGRESSIVE tuberculosis sanatoriums find their rehabilitation services a powerful weapon in the fight against this merciless ravager of the youth of our country. Scientists and related experts in the fight against tuberculosis have long admitted that while active tuberculosis is brought about by the tubercle bacillus, the spread of tuberculosis among our young men and women can be traced to a complexity of sociologic, psychologic and economic problems aggravated by our accelerated tempo of living.

For more than forty years, we have been treating and arresting the disease at the sanatorium. Until recently, this was done on a purely medical basis. Inadequate attention was paid to those socio-economic factors which were so largely responsible for the breakdown of the patient. The fact that the same unfriendly situations were awaiting the patient outside of the sanatorium after the arrest of his tuberculosis did not seem to alter the myopic treatment of this problem, with the result that it often proved to be a limited and, therefore, incomplete effort.

Why They Suffered Relapses

The patient, after months or even years of sheltered care at the sanatorium under a strict regimen of rest, was suddenly returned to his former environment to face, in addition to the same perplexing problems that precipitated his breakdown, the keen economic competition of his healthy neighbors. Many of these patients suffered relapses and returned to the sanatorium for another extended and perhaps less fortunate stay, at preventable expense to the community.

Today, our thinking in terms of cure at the sanatorium seems simple, obvious and much more constructive. Medical arrest of the disease is not sufficient in itself nor can it release us from further obligation to our patients. A thorough survey of the social and economic background of the patient is essential, particularly since these patients are so often in the lower economic brackets. Wherever indicated by the social diagnosis, adjustments in the patient's mode of living should be made for him if not by him. This requires the application of the best that medical social service has to offer, not only at the sanatorium but also in the home of the patient.

In order to achieve a reasonable measure of economic security under conditions that will ensure the permanence of the clinical result, it may be necessary to reorganize the patient's entire economic, which often means vocational, status. He must be retrained in work suitable to his arrested condition, corresponding to his limited abilities and temperament reaction.

This procedure has been termed rehabilitation. It starts in the sanatorium and requires sympathetic interest and cooperation of doctor, nurse, social worker, psychiatrist, teacher, occupational therapist, librarian, vocational conselor and state rehabilitation service representative.

In order to attain the optimum results in such an important hospital program and with so many cooperating services, it is necessary for one person to take over the important assignment of organizing the rehabilitation program and to coordinate the facilities for training all interested services. For the purposes of this article, we shall call this executive or department head the rehabilitation director.

To be able to provide leadership with this problem, the rehabilitation director must be well trained in his specialty through a varied formal academic career as well as by a thorough specialized training program. Since we are dealing with sick human beings and their families and are planning for their comfort and future, we must not employ inexperienced, though well-meaning, individuals to undertake so important an assignment.

Too Few in the Field

At the present time, there are still comparatively few people in this field with proper training to undertake the development of rehabilitation programs in tuberculosis hospitals. Taking my personal experience as an example, I have been approached by six medical superintendents of tuberculosis hospitals in the metropolitan area on this subject during the past few weeks. They control approximately 2500 beds for tuberculosis and were eager to establish up-to-the-minute rehabilitation programs in their establishments. They were seeking rehabilitation experts to survey their facilities and undertake the inauguration of rehabilitation programs. They were prepared to pay about $3500 annually for qualified executives. It appears that this situation is duplicated in many other places throughout the entire country.

Tuberculosis hospitals are aware that a constructive program of rehabilitation will help them to capitalize on the many advances in diagnosis and treatment that are constantly being made in tuberculosis. They can seldom, however, find an individual sufficiently trained to undertake such progressive work.

Furthermore, tuberculosis is not

the only area in which the services of the trained rehabilitation director are being sought. There are rich pastures in long-term handicaps, which include the blind, the deaf, the crippled and the cardiacs. There are also the vast field of psychiatry and the opportunities to be found in industrial medicine.

The peak need for well-trained rehabilitation directors will come shortly after the war, when a great many of our military casualties will require rehabilitation, both physical and vocational. The federal government, recognizing this development, has already legislated and appropriated funds to establish rehabilitation programs for returning service men and women. It has latterly shown great and heartening interest in a comprehensive rehabilitation program for the handicapped civilian as well, through state facilities. Little, however, has been done thus far in this country in the preparation and training of the numerous rehabilitation directors who will be needed after the war.

Confused as to the Need

At the annual meeting of the National Council of Rehabilitation in June 1944, a committee on personal qualifications, standards and facilities for training submitted a report. The committee established contact with 120 American colleges and universities. The replies received indicated a considerable amount of confusion in the minds of many reputable educators on the significance of rehabilitation and the method of its application. Few, indeed, recognized the possibilities of rehabilitation as a useful field of professional activity.

Teachers College of Columbia University, New York University and Western Reserve University have recently offered to the graduate student periodic orientation courses in the field of rehabilitation. These universities have often reiterated the obvious fact that such courses do not constitute professional training but are only an introduction to the subject.

A number of universities seem to show a keen interest in the development and progress of rehabilitation and are sincere in their efforts to assume the responsibility of providing academically trained personnel. Unfortunately, they do not possess a clear picture of the proper application of the processes of rehabilitation and the methods of organization of such a program.

Recently, I approached one of our oldest and most renowned universities in the East, hoping to interest it in developing a program of education for the rehabilitation director. Its position was that it is vitally interested in rehabilitation but does not find it expedient to offer an over-all sequence for the genus rehabilitation director. It feels that rehabilitation is accomplished by a series of specialists, such as vocational counselor, psychologist, occupational and physical therapist, psychometrist, social case worker and teacher, and it undertakes to train such specialists.

Few of our educators have seen a practical rehabilitation program in action. From a purely administrative point of view, if one were to turn loose these various interested specialists on the rehabilitant without a director to coordinate their work, I fear that little of value would be accomplished.

The rehabilitation director, in administering the program, must be trained to oversee the entire rehabilitation planning of the handicapped individual, most of it on a long-term basis. He must first take into consideration the physical condition of the patient, his length of stay at the hospital, his chances of recovery, his work capacity and the time when he will reach his maximum work tolerance. There may be social problems for the patient or the family from which he is separated, economic problems, psychologic and adjustmental problems.

The well-trained rehabilitation director in the process of developing the rehabilitation plan for the patient will fit in the various specialists at a period in the long-term plan when the patient can benefit most from their services and when the efforts of one specialist will not interfere with those of another.

It is obvious that these administrators in the field of rehabilitation should possess a good knowledge of the work of all the interested specialists. These men and women must be specially trained. The course of training for such specialists should be offered preferably in the university schools of education. It should be given on a graduate level and be of from one and one half to two years' duration and should include from six to nine months of practical internship in the various phases of rehabilitation, namely, in the hospital, with the public rehabilitation services and with related private community resources. The course of training should lead to a master's degree.

The study program should include, in addition to psychology and introduction to mental hygiene, the following suggested courses:

1. Introduction to rehabilitation.
2. Elementary and advanced theory of occupational therapy.
3. Occupational analysis and information.
4. Measurement of intelligence (including practice in administration and interpretation).
5. Case studies in rehabilitation.
6. Descriptive statistics
7. Counseling technics
8. Vocational tests and measurements (including practice in administration and interpretation).
9. Placement and personnel procedures.
10. Social case work theory.
11. Problems and methods in adult education.
12. Labor problems and legislation.
13. Community organization and resources.
14. Recreation for the handicapped.

Number of Handicapped Increases

Rehabilitation, as a profession, is here to stay. Today, in this country, approximately six million people require physical and vocational rehabilitation to some degree. Every year a million people become handicapped through accident or disease and can benefit from a program of rehabilitation. The war is increasing the total number of handicapped civilians.

When we add the handicapped soldiers to this number, the importance of the need for rehabilitation stands out in bold relief. The federal and state vocational rehabilitation services, the Veterans Administration and the vast number of community agencies set up to rehabilitate these people are showing signs of vital interest and growth.

In order, however, to maintain a high level of efficiency we must have properly trained and qualified rehabilitation executives. Many eligible individuals will appreciate an educational opportunity to enter this inviting field of social usefulness.

INCLUSIVE RATES
Affecting Special Services

MORRIS HINENBURG, M.D.
Executive Director, Jewish Hospital, Brooklyn, N. Y.

OPPONENTS of an all-inclusive rate plan of charges for hospital services tell us that its application tends to increase the cost of hospital care because it stimulates an increase in the demand for diagnostic and therapeutic services. They argue that this increase in cost is reflected gradually and inevitably in the purchase of more supplies and the employment of more personnel for the departments in which the increased demands must be met and hold fast to the principle that the costs of service to private patients should be borne directly by the recipients of such service.

They criticize the inclusive rate plan because it increases the financial burden on patients who have limited need for chargeable "extras." They do not agree that it is fair to spread the cost in this way.

Blue Cross Is Inclusive

On the other hand, friends of an all-inclusive rate plan lean heavily on the inclusive service provisions found in subscriber contracts of many Blue Cross plans. When voluntary hospital insurance plans were first established, the range of discussion about their benefits and their limitations included warnings about the possible exploitation of hospital services that might ultimately undermine the confidence of hospital and public in them.

With the passing of the years, hospitals generally have kept pace and worked well with the Blue Cross movement. Criticisms of the inclusive rate features of the program have been sporadic and limited to a minority group of specialists in the medical profession.

According to some, the foundations of voluntary hospital insurance plans may be undermined eventually by an expanding gap between the capacity of subscribers to pay premiums and the mounting costs of hospital care. But this is an alarmist reaction, which has no basis in fact.

The basic benefit of the inclusive rate plan is the provision of essential hospital services for every patient, depending on the clinical indications for these services. In actual practice, we do not see an unreasonable use of special services. Under the old plan of separate cumulative charges, semiprivate and private patients may be denied special services because they cannot afford to meet the cost. Each item must be weighed in the balance before a charge is incurred, and this is discouraging to doctor and patient alike.

On the other hand, ward patients may have such service by simple prescription and the question may therefore be raised, on behalf of the patients who pay the full cost of hospital care and often more: "Why discriminate against private and semiprivate patients and deprive them of diagnostic and therapeutic service when it is handed out to ward patients?" The inclusive rate plan is the logical way to provide these benefits for all paying patients in the hospital.

Some increase in special services under an inclusive rate plan must be foreseen, budgeted and carefully considered in our planning. We must provide deliberately for the anticipated increase in use, and the rate structure of charges must be correspondingly adjusted. These increased costs are best neutralized by a small additional premium chargeable to every patient without exception. Indeed, this small additional premium is not prohibitive, nor does it justify the argument that the plan contributes to the rise in costs of hospital care.

The patient who has no occasion to make use of all of the available services, because he has no clinical indications to justify them, pays but a modest additional premium for the satisfaction of knowing that these facilities are at his service if they should become necessary.

No problem of exploitation (requisitions for services unsupported by clinical needs of patients) in connection with the special services of the inclusive rate plan will arise if the relationships between the clinical divisions of the hospital (the visiting medical staff) and the laboratory divisions are planned on a consultation basis. The latter should not be treated narrowly as technicians but broadly as specialists serving the patient professionally in cooperation with everybody else.

The effect of this cooperative approach to the diagnostic and therapeutic requirements of patients in our hospitals has been a general agreement to limit special services to those which are essential in the clinical management of patients. There are occasional instances of misrepresentation to gain advantages while the patient is in the hospital, but in actual practice they are insignificant in the long run.

Absorb Cost of New Services

Some have reported that an all-inclusive rate tends to discourage the introduction of new procedures and methods because of the costs involved. Increases in rates, no matter what the plan for charges may be, follow the introduction of services which add to cost since they must keep pace with each other. There is, however, more encouragement to absorb new services without increasing rates to patients under the inclusive plan than under the day-plus-extras schedules.

Separate payment for each item of service effectively controls its use. Under such a plan of payment, abuses are practically impossible. The hospital, however, does not serve a social purpose in the community by holding rigidly to such hard-headed business philosophy in its approach to health and welfare problems.

The primary purpose of the hospital is to provide complete care for the sick and injured. We must not deny to any patient some special service because he is unable to meet the expense. Patients enter hospitals with the expectation that they will be led gently back to health. The knowledge that the full resources of the hospital are at their disposal is

Table 1—Average Cost per Patient Day

Hospital No.	1937	1938	1939	1940	1941	1942	1943
PRIVATE PATIENTS							
*1	9.40	10.81	8.02	8.79	8.70	8.83	10.11
*2	8.34	8.30	8.45	9.27	9.16	8.36	9.22
*3	10.16	10.21	10.55	10.80	12.50	12.78	12.08
4	11.91	12.90	11.02	10.23	11.85	12.75	12.18
5	9.90	11.31	11.15	12.40	11.49	13.09	14.08
6	7.83	8.33	7.82	8.54	9.23	10.47	11.04
7	12.56	12.60	12.36	11.67	12.60	13.04	13.33
SEMIPRIVATE PATIENTS							
*1	7.86	7.60	7.10	7.54	7.89	7.61	7.53
*2	8.12	8.08	7.68	8.23	8.20	7.97	8.41
*3	8.79	8.73	8.54	8.75	8.12	9.41	9.36
4	9.68	9.39	8.89	8.57	8.53	8.44	9.40
5	7.59	7.25	7.71	8.50	7.97	8.97	9.56
6	6.29	6.30	6.23	7.16	7.52	7.25	7.86
7	8.48	8.34	8.35	8.35	8.92	9.22	9.66

*These hospitals maintain inclusive rate plans.

Table 2—Annual Ratio of X-Ray Examinations per Hundred Patients

	1935	1936	1937	1938*	1939	1940	1941	1942	1943	1944
Private and Semiprivate	38	37	43	54	68	63	58	49	50	50
Ward	81	88	96	99	125	135	116	112	114	133

*Inclusive rate plan adopted April 1938.

comforting to them, to their doctors and to the governing body.

The inclusive rate program was started at the Jewish Hospital of Brooklyn, N. Y., seven years ago. Our experience with it convinces all of us that the plan as a whole is wise and its continuation, justified. Drawing on the experience of the last seven years to meet the accusations (a) that costs spiral upward under this system because of increased and uncontrollable utilization and (b) that the day-rate plus-extra charges do not possess the evils that are alleged to be a part of the inclusive rate plan, several tables of data are presented here to indicate the per diem cost and the ratio of examinations performed in several of the special departments.

The figures in table 1, taken from the annual reports of the United Hospital Fund of New York, show the average cost per day for private and semiprivate patients (a) in three hospitals maintaining an inclusive rate plan of charges and (b) in four hospitals of comparable size and function to the first three maintaining a day-plus-extra system of charges. A study of the figures will not enable the reader to associate the hospitals with the plan of charges maintained in them.

From these figures it will be noted that increases in cost have taken place in hospitals without the inclusive rate plan during some periods when costs in some hospitals with the inclusive rate plan declined. The answer to the question about rising or declining costs in either group cannot be found in the plan of charges. Other factors, peculiar to the hospitals themselves, are most likely responsible for the reported changes in cost.

The claim that special services under the inclusive rate plan are utilized to a degree that will make the continuation of benefits to patients an actuarially unsound practice has no special merit in our experience. Judging by our experiences in the x-ray department (table 2), the inclusive rate plan has served its real purpose in making x-ray examinations available to patients who would have been compelled to do without them under the pay-as-you-go plan. The demands for x-ray services have not exceeded the anticipated rise and were readily met without an increase in the personnel of the department.

A comparison of the number of examinations performed for ward patients with that for private and semiprivate patients shows that the former was, for most years, about twice that of the latter. Without positive controls, the ratios for private and semiprivate patients may easily have approximated the ward ratios, for it is generally known that special services for ward patients in the free and part-pay classifications are subjected to liberal controls.

Our experiences with the impacts of the inclusive rate plan on other special service departments of the hospital parallel those for the x-ray department. The accompanying tables 3 and 4 show the increases in electrocardiographic examinations and basal metabolic determinations. The figures for the laboratory are not submitted because such examinations have been charged for on a flat rate basis for many years, without resorting to an item basis for charges.

Rejection of the inclusive rate plan should not be based on the fear of unpredictable increases in cost and uncontrollable exploitation of the special services made available by the terms of such a plan. The inclusive rate plan removes the worry of the cost factor from the mind of the patient, already burdened by illness and its attendant worries, who requires a substantial amount of

Table 3—Annual Ratio of Electrocardiographic Examinations per 100 Patients

	1935	1936	1937	1938*	1939	1940	1941	1942	1943	1944
Private and Semiprivate	5.9	6.2	7.2	9.9	11.9	11.7	10.4	8.3	8.5	9.1
Ward	13.6	16.2	17.4	15.2	20.8	24.4	24.9	24.9	28.6	32.4

*Inclusive rate plan adopted April 1938.

Table 4—Annual Ratio of Basal Metabolic Determinations per Hundred Patients

	1935	1936	1937	1938*	1939	1940	1941	1942	1943	1944
Private and Semiprivate	3.4	4.1	3.6	5.3	5.2	4.4	4.4	3.1	2.9	3.2
Ward	5.9	6.4	6.8	7.6	7.7	6.8	6.1	6.4	8.1	8.8

*Inclusive rate plan adopted April 1938.

service. In an institution desiring to teach as it goes, the special data on private and semiprivate patients are as valuable as those on ward patients to the vital resources of its teaching program.

Physicians bear a professionally competitive relationship to one another in private as well as ward practice and naturally shun the spotlight of incompetency which follows from an inadequate work-up. Given the opportunity to meet the diagnostic and therapeutic requirements of patients without repeated reference to their pocketbooks, the level of medical service is raised.

There may be good reasons for rejecting an inclusive rate plan but these do not include the matters of costs and the recognized social principle of "spreading the risk."

A Chaplain Is Needed

in the psychiatric hospital

REV. ERNEST E. BRUDER
Protestant Chaplain
St. Elizabeth's Hospital, Washington, D. C.

WITHIN the last year the American Protestant Hospital Association published the first systematic study of the present state of religious work in mental disease hospitals.[1] It commands the interest and consideration of those in administrative, medical or religious capacities who are responsible for the care of the mentally or emotionally ill. Granted the study is not exhaustive, it is at least suggestive and brings out sharply some of the major considerations in the problem.

Lack of Organized Work

It is stated that "despite some encouraging signs of progress, the protestant religious ministry in our state and federal hospitals is seriously deficient." Perhaps the most signal evidence of this deficiency is to be found in the lack of organized, sustained and trained chaplaincy work itself. We are told that 13 hospitals have full-time chaplains; we know from other studies by the same author[2] that less than half of these have had specialized training in this particular field, and that of the 53 part-time chaplains, 37 give no more of their time than that needed to conduct worship services.

It is in this area that we find our greatest criticism, for unless the chaplain has been trained he cannot hope to use effectively the skills and resources that are available to him in this highly specialized branch of the Christian ministry. It is not without significance that 30 per cent of the hospitals without full-time chaplains that expressed the desire for them did so with the provision that they be "trained to meet the special needs of mentally ill patients." And one may be led to speculate as to how many of the 64 hospitals that replied that they were either satisfied with present arrangements or simply did not want full-time chaplains knew that it was possible to obtain men specially qualified for this work.

That there is real need for a trained chaplain and that he is able to make a positive contribution to the patient's welfare are truths by no means as yet clearly recognized by hospital personnel. Unfortunately, in many cases these medical workers have had knowledge and contact only with clergymen who have been trained to make fine theological distinctions but who have had little or no understanding in the technics of helping people who have had difficulty in the areas of human adjustments.

However, where the trained clergyman has been in a position to demonstrate the usefulness of his function, the hospital administrator has been quick to recognize the part he could play on the therapeutic team of physician, nurse and other professional workers whose job it is to help people achieve harmony in their interpersonal relations.

Since it is suggested on the basis of this study that the key to the problem lies in the need for trained workers, it might be well to inquire just what type of service could be rendered by such men.

For some time it has been my contention that the most valuable contribution a trained chaplain could make would be the interpretation and application of the resources and practices that are the clergymen's pastoral heritage to the special problems associated with mental illness. Worship, prayer, counseling, preaching, religious education, the use of the scriptures and sacraments, when adequately utilized, have long been the means whereby the church has sought to help people live effectively. Properly understood and intelligently applied these prove to be of inestimable value to those who have been emotionally upset.

In working with those who are patients in mental disease hospitals one becomes aware rather quickly of their great feeling of anxiety and insecurity. No doubt these feelings are inextricably bound up with the accumulated tensions that underlie the illness, but in any case they are frequently aggravated by the fact of hospitalization. In this connection one needs hardly be reminded of the community attitude toward mental illness and the measures often resorted to by relatives to get the patient into the hospital. It is precisely at this point that the services of the chaplain can be of real help.

Interprets Hospital to Patient

By skillful interpretation to the patient of the reason for the hospitalization, the hospital's routine and desire for the patient's recovery and return to society, as well as his own use of the strictly religious resources, such as prayer and worship, the chaplain can help the patient gain a greater sense of security and acceptance of the total situation.

No treatment can prove really helpful unless there has been some conscious articulation on the part of the patient of the fundamental prob-

[1]Protestant Religious Work in Mental Hospitals. Report by Rev. Seward Hiltner, executive secretary of the Commission on Religion and Health, published by American Protestant Hospital Association, 1944.

[2]Rev. Seward Hiltner: Religion and Health, New York, The Macmillan Company. 1943.

lems involved in the illness. It is here that the psychiatrist seeks to help the patient gain a measure of true insight: here we have the therapist's concern with "content." Only when the patient can feel free and secure enough to offer such articulation can genuine treatment be established. It is at this point that the trained chaplain can be of help to both the psychiatrist and the patient.

Frequently, there are certain areas of personal living in which real difficulties of adjustment have been experienced but which the patient refuses to divulge to the doctor. The reasons for this may be varied. Some have said "I don't want this to go into my medical or service record which I know is being kept by the hospital" or "since you are a clergyman I know that what I tell you will go no further." Or, again, the patient's previous experience may have been such that he finds it easier to talk to a clergyman than to a doctor.

No matter what the reason, if the patient is unwilling to confide in the therapist no real progress can be made in the doctor-patient relationship. The chaplain can be helpful here if, on the basis of understanding and experience, he knows something of what the patient is expressing by these statements and then leads him to a more positive attitude toward both the doctor and the hospital.

The Approach Is Different

It might be well here to point out a fundamental distinction between the function of the chaplain and that of the psychiatrist. Both are obviously concerned with therapy; both seek the patient's return to society but while the psychiatrist's basic concern is with "how" and "why" the individual has experienced difficulty in his personal relationships, the chaplain's task is that of helping the patient in the treatment process itself and also in making his adjustments to those with whom he lives in the community.

It is not the chaplain's field to probe into the dynamics of interpersonal relationships; rather, he should work with the psychiatrist to lead the patient back into more creative and positive attitudes that will make for happiness in living.

Perhaps the most outstanding single characteristic in the constellation of feelings associated with mental illness is the feeling of personal isolation. It may be fairly evident on the conscious level and be expressed in terms of the social stigma usually connected with mental illness, or it may be concealed in the many and elaborate manifestations surrounding the presence of marked feelings of guilt.

One is led to doubt that this feeling is due only to the social attitude toward mental illness; it seems much more likely that the mentally ill feel themselves isolated or ostracized because of their own strongly unacceptable unconscious feelings which in their thrust toward consciousness have precipitated the illness. But, whatever the cause, the fact is that the patient either believes or acts, or both, as though he were not an acceptable member of the community family. And it is right here that the chaplain can make perhaps his most distinctive contribution.

In the first place the chaplain represents to the patient a concrete link with the community from which he feels himself estranged. The chaplain may be a hospital staff member, as indeed he properly should be, but in any event he cannot be dissociated from his connection with the church. As such, he is never for the patient distinctly and only "hospital" as are perhaps the other staff workers. Thus ministering to the patient, the chaplain can be used as a bridge to lead the patient back into communal living.

As has been suggested, one of the great needs of the patient is to be helped to put some of his difficulties into words. When he is able to do this, aided by the friendly and understanding attitude of the chaplain, he undergoes an experience of d o u b l y significant psychological value. Not only is he able to gain "release" but he does so through one who symbolizes for him the community's critical and prohibitive attitudes. It may then come to mean for the patient, though perhaps the thought is never actually put into words, "If he doesn't condemn me then I'm not as different as I thought I was." This can be of great positive value in terms of the chaplain's other function in helping to reeducate the patient so as to enable him to see himself, his needs and desires and the community standards in a much more realistic light.

Not the least of the resources available to the chaplain in overcoming these feelings of isolation is what can be done with the potentialities of the worship services. By careful selection of hymns and scripture passages and by the use of preaching which is geared to the real life situations of the patient, much of positive value can be offered.

Here the patient can, with others, offer up collective prayers and affirmations that deal with basic drives and difficulties. Here the groundwork can be laid for future consideration with patients of their feelings in given situations; here the patients can get the feeling associated with group activity, that is, that they are not alone in their particular experiences. And here also one finds in this doing of things together (prayer, hymns, responsive readings, affirmations of faith) an effective means of socializing through which the patient finds yet another way of making his way back to an adequate community adjustment.

Areas Still to be Explored

There are still other areas of service in which the chaplain could prove to be of real help, but for the purpose of this article they need only be suggested. Some of these are being explored by the few workers already in the field; others, for the present, merely offer intriguing possibilities.

Those already being explored include the chaplain's opportunities in community relationships and education; his educational responsibility both in studying the psychology of religious processes and experiences and in training theological students in the principles underlying good pastoral care, and the education of local clergymen in their pastoral opportunities toward their own parishioners who may be in the hospital.

However, as implied in the findings of Seward Hiltner's study, all these possibilities resolve themselves about one cardinal factor, that the chaplain must be a full-time staff member of sound and adequate clinical training[3] as well as a clergyman conversant with the skills and resources of his religious faith and practice.

[3]Detailed information about trained chaplains can be obtained from the Council for Clinical Training, Inc., the Academy of Medicine, 2 East 103d Street, New York 29, N. Y., or Box 122 St. Charles, Ill.

The Pupils Were Prepared
to answer the call for aides

ELSA SEIDSCHLAG
Seaside Memorial Hospital
Long Beach, Calif.

IN PEACE time Long Beach, Calif., is the home port of the Pacific fleet. Its population in 1940 was approximately 167,000. The increase of population after Pearl Harbor was rapid and relatively constant, reaching an estimated 350,000 by July 1944, exclusive of military personnel. The enormous expansion of the shipbuilding and aircraft industries and increasing harbor activities were the causes of the great influx of workers.

An increase of the general population always brings a proportionate increase in hospital census. With no opportunity for increasing the physical plant of the hospital and a rapidly dwindling graduate nurse staff, Seaside Memorial Hospital of Long Beach was faced with a serious problem. The administration, however, was determined that civilian health would not be put in jeopardy and prepared to meet the challenge.

The sprawling character of the hospital building makes staffing difficult. The building is a block long. Some department errands, therefore, are in reality a two block walk for the messenger. It was quickly apparent that this time-consuming work had to be done by auxiliary help.

The best source of help available was the teen age girl who could be interested in and educated for useful service to the sick. These young girls are now contributing generously to the patriotic and humanitarian efforts of their countrymen in this great war.

The Victory Aide Corps, organized in Long Beach as a joint hospital and high school project, had its inception in July 1943. Membership in the corps was made contingent upon satisfactory completion of the victory aide home nursing course in high school. The teachers of the course recommend the pupils for work experience in the hospital when they reach a point at which they will be useful and safe helpers.

The corps is a citywide project with public and Catholic high school pupils participating. From this point forward this article will treat of the corps and its relation to this hospital. The victory aide home nursing course was scheduled for the summer session of the Polytechnic High School, the largest in Long Beach, in 1943. The course was taught by the homemaking teacher in her department. The hospital cooperated by sending a nurse, qualified to teach, to the high school to talk on prenatal work, the functions of a modern hospital, nursing history and the bed bath. The time given by the nurse amounted to approximately ten hours. By the middle of July 1943 20 victory aides were giving this hospital volunteer service. They were assigned the hours when the nursing load was the heaviest: 8 a.m. to 12 noon, or 3 p.m. to 7 p.m. They ate in the nurses' cafeteria free of charge. Supervisors and charge nurses were privileged to negotiate with the victory aides regarding their hours of

Folding and putting away linen is one of the services performed by the high school victory aides that takes just one more burden off the staff.

service so that the maximum benefits might be obtained for the patients.

The service given by the corps averaged from 1000 to 1200 hours a month. This was an enormous lift for the overworked, nerve strained graduate nurse staff. These teen age girls soon became proficient in many simple nursing duties and ran all the interdepartmental errands. Their work was supervised by the nurse instructor. Careful records were kept of their time and each pupil was given a certificate by the hospital when she had served a hundred volunteer hours.

The summer of 1943 came to a close. The project started in the summer had been such a delightful experience for all concerned that steps were immediately taken to have it continued for the duration and into the peace, if possible.

The home nursing course is a regular part of the high school curriculum. The teacher and the nurse instructor of this hospital again collaborated to prepare the pupils of the new class for membership in the Victory Aide Corps and work experience in the hospital. The same success was enjoyed. The puipls were willing and eager helpers.

Debate Pay for Service

Because the need of this auxiliary group was so great the superintendent of this hospital thought it best to pay the victory aides for their services. It was debated that some of the character-building elements might be lost if the pupils received pay, so a compromise was agreed upon. The victory aides were to give six hours of volunteer service each week and be paid 50 cents an hour for all time over that. As a result, this hospital has had an average of 15 victory aides giving some service each day when the nursing load is heavy. During the school year 1943-44 the victory aides served 11,056 hours.

In June 1944 the question came up as to whether the hospital would lose the services of the victory aides during the summer vacation. Would the Polytechnic High School schedule the victory aides home nursing course for summer school? The school was approached by the hospital and the need for victory aides was again stated. The principal of the school, Howard H. Hicks, responded with fine understanding. The course was scheduled.

Needed More in 1944

The summer of 1944 found the discrepancy between the number of graduate nurses and patients wider than at any previous time and the services of the victory aides were needed more than ever before; and the corps performed in an unprecedented manner. During July 1944 the victory aides gave 2200 hours of service.

The benefits to the pupil aide are manifold. It is apparent that the transitional period of adolescence is made smoother, a bit less turbulent by her association with graduate nurses and by the quality of the hospital. The graduate nurse presents a high standard of womanhood; she is the adolescent's exemplar. As a corps member the pupil develops a strong sense of loyalty to the corps. In her service to others she develops a loyalty to something bigger than herself, loyalty to a principle.

In the practical realm the most useful and lasting benefits lie in the aide's overcoming a fear of sickness and shyness to approach the bedside of the sick and in the development of certain skills employed in the care of the sick. She will be a better wife and mother. Her knowledge of the functions of a modern hospital and her participation in its functionings will increase her sense of civic pride and civic duty.

Whether she later chooses nursing as a career is irrelevant. However, should the pupil be so minded she will be less likely to enter a profession for which she has no taste. Because it has been apparent that the corps operates to the benefit of the pupil in numerous ways it seems highly desirable that it should be continued into the peace.

The contribution of the corps to the hospital has been gratefully stated. The intangible values are more difficult to put in words. The victory aides give of their youth. They bring their radiant health to the bedside of the sick, which is a tonic not to be underestimated. Their cheerfulness, their eagerness, their zest for life are like a clean fresh breeze through the hospital, which is felt by all.

Practically speaking, these girls are a controlled group of helpers; the quality of their work is excellent; they understand their rôle and are ethical in their attitudes toward patients, nurses and visitors. They are appreciated by the supervisors.

They Have Play Time, Too

The corps has less serious moments, too. Once a month the hospital provides a large cake and sufficient milk for refreshment. This is either served on the hospital premises or taken to the beach and enjoyed after a swim. During the regular school year the nurse supervisor meets with the victory aides and their teachers to give an informative talk on any nursing subject that the girls may be interested in at the time. At these monthly meetings the corps conducts its business and formulates its policies.

This great reservoir of help and understanding was surely always with us. It was merely necessary to discover and put it to use. The magnanimity of the several persons in the high school who made it possible for the pupils to organize for service will become the spirit of the corps. The splendid cooperation of hospital and high school, now established, should continue to the benefit of all.

Reactions to the Hospital Surveys

1. ROBERT E. NEFF, Administrator, University of Iowa Hospitals, Iowa City

THE schedules of information prepared by the Commission on Hospital Care, even on casual examination, give evidence of far-sighted planning; more careful scrutiny convinces one of the keen insight into matters of hospital operation on the part of the designers of the schedules, and when one actually fills out the questionnaire it becomes all the more impressive for the practical manner in which they set out to accomplish the purposes for which the schedules were designed.

Obviously, a complete inventory of hospital facilities throughout the country by means of a uniform inquiry among all hospitals requires a questionnaire that is versatile, adaptable and all-inclusive. The gathering of information of such wide range involving the numerous activities embodied in the modern hospital organization presents an interesting problem in statistics which naturally challenges the ingenuity of the best planning.

The schedules appear rather formidable at first glance, particularly to the administrator who does not keep complete hospital statistics and essential information in annual report form, but as one goes through the schedules page by page any impression of burdensome detail changes to one of fascinating interest. The schedules can serve as a checklist in keeping hospital records and the compilation of an annual report and, no doubt, will inspire many hospitals to keep records in more complete form. Careful study of the schedules by governing board members will doubtless inspire greater responsibility on their part toward better hospital development as well as bring to light deficiencies existing in their hospital organizations.

The schedules request little information that could be classed as superfluous or unnecessary when one considers the essential nature of the survey and the importance of having all types of information available for the studies leading to the ultimate execution of the commission's plans. Particularly to those administrators who may be members of the commissions charged with making surveys in their respective states do the schedules prove illuminating and helpful as they plan the program of gathering information.

The task of providing complete information on the schedules is time-consuming. In fact, administrators who do fill out the schedules completely will in all probability find that it will require from eight to twelve hours to complete the task.

It would be impossible to design any questionnaire in which all statistics available in an annual report could be set into the schedules without some adaptation, alteration or qualification. However, the schedules lend themselves remarkably well to adapting the facts and statistics which the well-organized hospital should have readily available.

Universal agreement, perhaps, could not be reached regarding everything that might be considered necessary for such a schedule from the standpoint of a critical analysis. Almost every administrator with broad experience could suggest additional questions. As an example, it might appear that the survey should call for more complete information regarding existing facilities in hospitals for the care of communicable diseases, the emergency care of mentally disturbed patients, care of chronic disease patients and also to what extent tumor clinics may exist in hospitals today. It would appear that the survey should bring forth more than census figures regarding these facilities which are so essential in the modern hospital.

Obviously, many hospitals cannot provide all the information sought by these schedules but all hospitals should be able to supply sufficient information to enable the commission to make a reasonably good appraisal of the hospital's facilities and activities.

---

2. J. A. BLAHA, Business Manager
Grand View Hospital, Ironwood, Mich.

THE survey of hospitals in Michigan, under the direction of the Commission on Hospital Care, is going forward with the help and encouragement of hospital administrators. What are some of the advantages to the administrator and to the board of trustees and what is the general information requested in such a report are some of the questions asked by a great many interested hospital people.

When an administrator is handed the 40 page schedule of information, I would advise him not to be shocked by the apparent magnitude of the job ahead but to read all of the schedule carefully. After careful perusal, I am sure that he will forget that it is a big job and will agree with me that it is one of the most worth-while and comprehensive surveys that has ever been attempted in the hospital field.

The first question probably asked is: How long would it take me to prepare this voluminous schedule? According to my own experience it took ten hours to compile all of the statistics and typewrite the report of our 133 bed hospital and I found that these were the most interesting, educational and worth-while ten hours that I have spent in my long period as a hospital administrator.

First, Schedule "B" showed the areas served and the percentage of patients from each. This information has always been on our records, but we paid no attention to it until it was combined with other information contained in this report, which made it stand out prominently.

Second, the appraisal of our physical plant gave us some extremely interesting figures, of which we knew nothing, *i.e.* our complement of bed patients, the normal beds for

patients and also the potential beds for patients. This was so interesting and informative that I, together with my board of trustees, spent considerable time analyzing these findings. From this analysis we came to the conclusion that additional hospital space is essential.

Third, Schedule "D" presented us with some interesting data, which we had not heretofore compiled in the form in which they were presented in this schedule; the data show the service by pay status and the type of service and also the number of patients discharged and the number of days of each service.

The occupancy and length of stay were also interesting and instructive, primarily from the point of view of the computations being made both on a normal bed capacity and on our bed complement capacity. This, again, showed us that larger facilities are needed in order to give all services the proper space required.

Fourth, the analysis of the several departments was highly informative. I presume each administrator knows his key people, but it was both enlightening and refreshing to me to analyze all these departments from a new point of view.

I could go on through the entire schedule and present the numerous benefits that were derived by the administrator, as well as the board of trustees, from this schedule of information. However, since space does not permit of that, I will say in conclusion that all administrators and boards of trustees in the United States should get behind the Commission on Hospital Care and see that this worth-while program is carried forward to a successful conclusion. The information gathered on each hospital is of an inestimable value to the individual institution and the composite picture of all services gathered will give all of us an over-all picture of the shortcomings of our present hospital facilities, which will help us in formulating policies for the betterment of hospital care in America.

---

3. SISTER MARY NICHOLAS, Provincial House Sisters of Mercy, Detroit

IN ORDER to gather the material for the Michigan survey of existing health facilities, a 40 page questionnaire was developed and mailed to all the institutions listed as hospitals or convalescent homes, of which there are at least a thousand, so named, in the state. The schedules of information were to be in the hands of the hospital administrators for at least thirty days, after which time volunteer field workers were assigned to call upon the hospitals and assist in the completion of the schedules.*

I was assigned 15 hospitals owned and operated by the Sisters of Mercy in Michigan. These institutions have bed capacities of from 25 to 515. The largest hospitals, with well-developed departments and technical schools as part of the administrative responsibility, required the most time. Fortunately, these institutions were easy of access, and statistics were in such good order that it was stimulating to one familiar with hospital administration to pick up the information requested on the forms.

The hospital administrator and the department heads were most generous in presenting information. Each schedule of information required at least twelve hours of actual consecutive time, including typing of accumulated data; in addition to this time, an estimated average of three hours of travel was devoted to each schedule.

The schedules of information prove to the administrator the value of a well-organized hospital and the worth of the principles set up for good hospital administration by organizations, such as the American Hospital Association, the American College of Surgeons and the American Medical Association. Added to these are the suggested minimum standards offered by the allied fields, namely, the American Association of Record Librarians, the American Dietetic Association, the American Registries for X-Ray and Laboratory Technicians, the National Association of Nurse Anesthetists and the Association of Medical Social Workers.

Any discrepancy in tabulating statistics in a given department is revealed by what may be termed the "cross-examination," or the presentation of a statistical question in another form in a second place in the schedule. Information requested in these schedules cannot but help the busy interested administrator to inaugurate better administrative policies or technics in his hospital, if any are lacking.

The information derived from the accumulated data as interpreted by the Commission on Hospital Care will enable Mr. John Q. Public to recognize good hospital facilities in order that he may make a judicious choice when he or his family requires hospitalization in the future.

Standards Must Be Set Up

Schedules of factual information will surely point out to the Commission on Hospital Care the need for better and more intensive supervision of facilities for the sick, through state licensure of institutions providing the necessary medical, nursing and technical skills for both the preservation and recovery of health. It seems inevitable that certain standards must be set up as a minimum to which an organization must conform before it is allowed to function as a hospital or convalescent home.

In my opinion the field worker who is qualified to obtain the most accurate information is one who is acquainted with hospital administration in all departments. The one day institute for field workers and the criticism of an advance sample schedule submitted to the Chicago office contributed greatly to the ease of completing the schedules assigned.

In a few instances it was found that statistics were not kept in any detail and some time was consumed in obtaining the requested information. However, even this proved well worth while to the institution concerned, because the administrator will probably use the suggested questions as a basis for keeping data in the future.

There was no problem relative to financial schedules since all of the 15 institutions, with one exception, have the accounting department set up according to the principles of accounting suggested by the American Hospital Association. Incidentally, this one institution changed over to the accrual accounting system beginning the first of January 1945.

*Norby, Maurice J., How Michigan Takes Inventory. Mod. Hosp. **64**:75 (May) 1945.

About People

Administrators

Jacob Goodfriend has resigned as superintendent of Jewish Hospital, Philadelphia, to become director of the Beth Moses Hospital, Brooklyn, N. Y., succeeding **Arnold A. Karan.** Mr. Karan has taken over the superintendency of the Bronx Hospital, Bronx, N. Y., filling the position left vacant by the resignation of **William B. Seltzer.**

A. L. Mitke, formerly superintendent of Sunbury Community Hospital, Sunbury, Pa., is the newly appointed administrator of Nanticoke State Hospital, Nanticoke, Pa.

Rev. A. F. Wasson has resigned as administrator of Oklahoma Baptist Hospital, Muskogee, Okla., to accept the pastorate of the First Baptist Church at Taos, N. M. **J. Potter Cox,** president of Draughon Business College, Jackson, Miss., will succeed him as head of the hospital.

Bessie M. Upham, superintendent of Hillcrest Hospital, Pittsfield, Mass., for the last six years, has resigned to be superintendent of Amesbury Hospital, Amesbury, Mass. She succeeds **Edith Bennett.**

E. J. Milsom Jr., superintendent of Canonsburg Hospital, Canonsburg, Pa., for the last four years, has been selected assistant administrator of Garfield Memorial Hospital, Washington, D. C.

Alice G. Henninger has resigned as superintendent of Collis P. and Howard Huntington Memorial Hospital, Pasadena, Calif. Miss Henninger was formerly superintendent of Seaside Memorial Hospital, Long Beach, Calif., and Asbury Hospital, Minneapolis. She was second vice president of the A.C.H.A. in 1939 and was the California delegate for the A.H.A. in 1938.

Mrs. Maxine Rogers Smith, formerly manager of two Los Angeles hospitals, has been named superintendent of General Hospital, Santa Rosa, Calif. She succeeds **Bertha Levy** who has retired.

Robert A. Pontow has been named business manager of Colorado General Hospital, Denver, succeeding Roy Prangley.

Mrs. Mary R. Fader, superintendent of Heaton Hospital, Montpelier, Vt., has resigned but will continue to serve as superintendent until a successor is named.

Dr. William T. Clark has resigned as superintendent of Edward J. Meyer Memorial Hospital, Buffalo, N. Y., to become superintendent of Masonic Home and Hospital, Utica, N. Y.

A. S. Reaves, business manager of Memorial Hospital, Quanah, Tex., has been named administrator of the Jefferson Davis Hospital, Houston, Tex. **William D. Fiero** will succeed Mr. Reaves at Quanah.

Dr. Alvin R. Sweeney, U.S.P.H.S., medical director of the Marine Hospital in Cleveland, has resigned that position to become superintendent of Gallinger Municipal Hospital, Washington, D. C. In 1913, Doctor Sweeney was commissioned assistant surgeon of U.S.P.H.S. for immigration duty at Ellis Island, N. Y., and from 1915 to 1919 was in charge of public health programs relating to cantonment areas during World War I at Fort Worth, Chattanooga, Tenn., and at Fayetteville, N. C. He served as executive officer of the Marine Hospital at Ellis Island in 1938 and in 1942 was transferred to Cleveland.

Frank W. Hoover, president of the Illinois Hospital Association, has resigned as superintendent of Decatur and Macon County Hospital at Decatur, Ill. **H. Robert Haupt,** formerly business manager of the Macon County Tuberculosis Sanatorium, Decatur, has been appointed superintendent of the hospital to succeed him. **Myrtle McAhren,** first vice president of the association, will act as president.

Robert Jolly, administrator of Memorial Hospital, Houston, Tex., was honored recently by Baylor University at Waco, Tex., which conferred upon him the honorary degree of Doctor of Humanistic Letters. Mr. Jolly is a charter fellow of the American College of Hospital Administrators and has served as president of the American Hospital Association, 1935; American Protestant Hospital Association, 1931, and the Texas Hospital Association, 1931-32.

C. Robert Youngquist, administrative assistant at Episcopal Hospital in Philadelphia, for three years, has accepted the position of administrator of Jameson Memorial Hospital, New Castle, Pa.

William C. Walton has been appointed to the administrative staff of the Louisville General Hospital, Louisville, Ky. Mr. Wilson has been associated with the health department of the Tennessee Coal, Iron and Railroad Company of Birmingham, Ala., as works auditor for the General Hospital, plant hospitals and clinics.

Dr. Louis G. Beal is the new administrator of State Hospital, Morganton, N. C.

Harry D. Keller, formerly director of public relations at Coe College, has been named administrator of Iroquois Hospital, Watseka, Ill.

Capt. Robert M. Schnitzer of the Seventh Medical Depot Company has been promoted to the rank of major. He was formerly administrative intern at Orange Memorial Hospital, Orange, N. J.

Mrs. Edna Scroggie has been appointed superintendent of Greenfield Municipal Hospital, Greenfield, Ohio, succeeding **Helen N. Yarnell** who has resigned.

Department Heads

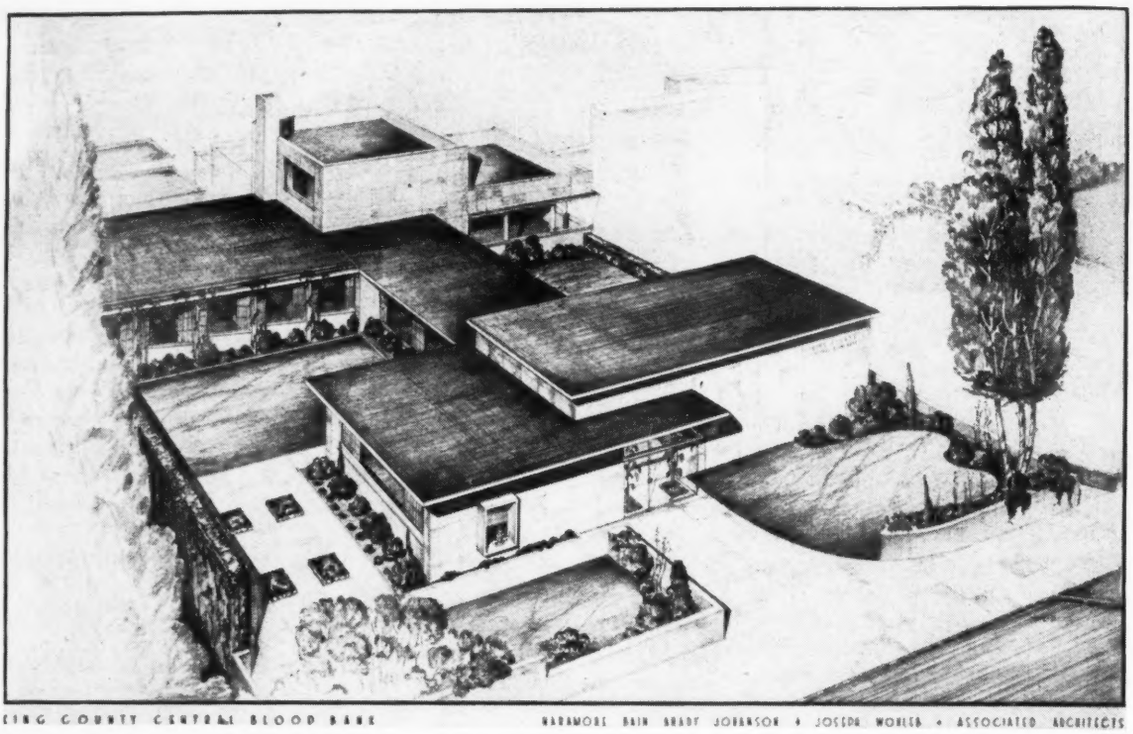
Mrs. Effie M. Armitage, formerly executive housekeeper at Methodist Hospital, Sioux City, Iowa, has been named executive housekeeper at Ashtabula General Hospital, Ashtabula, Ohio. Mrs. Armitage was formerly executive housekeeper at Grant Hospital in Chicago.

Frank J. Steele has been appointed pharmacist and purchasing agent at Greenwich Hospital, Greenwich, Conn. Mr. Steele is a graduate pharmacist and was formerly identified with Johns Hopkins.

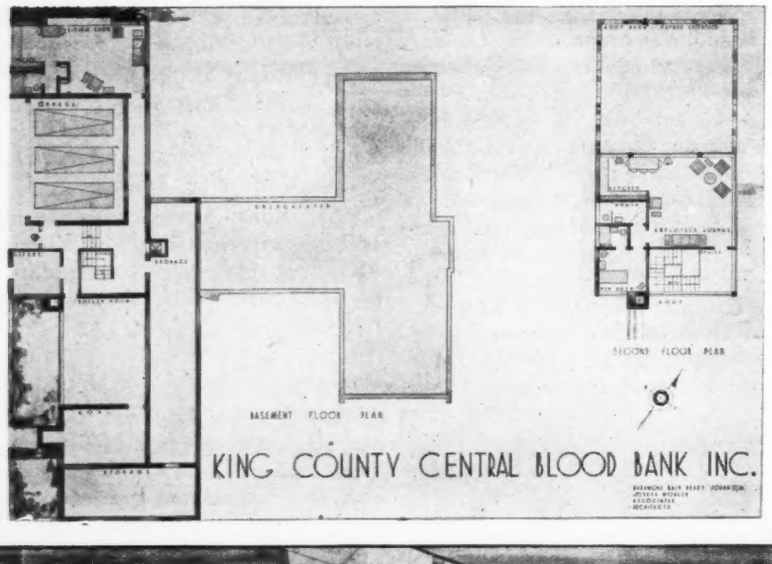
Charles Richardson, formerly in business in Rochester, N. Y., has succeeded **Paul Burroughs** as purchasing agent at the Rochester General Hospital. Mr. Burroughs has become purchasing agent for Pennsylvania Hospital in Philadelphia.

Mrs. Nan H. Ewing has succeeded **Rachel F. McCrimmon** as director of nursing and principal of the school of nursing at Vassar Brothers Hospital, Poughkeepsie, N. Y.

(*Continued on Page* 142)



Aerial view of the proposed blood bank. Naramore, Bain, Brady, Johnson, Joseph Wohleb, Associated Architects.



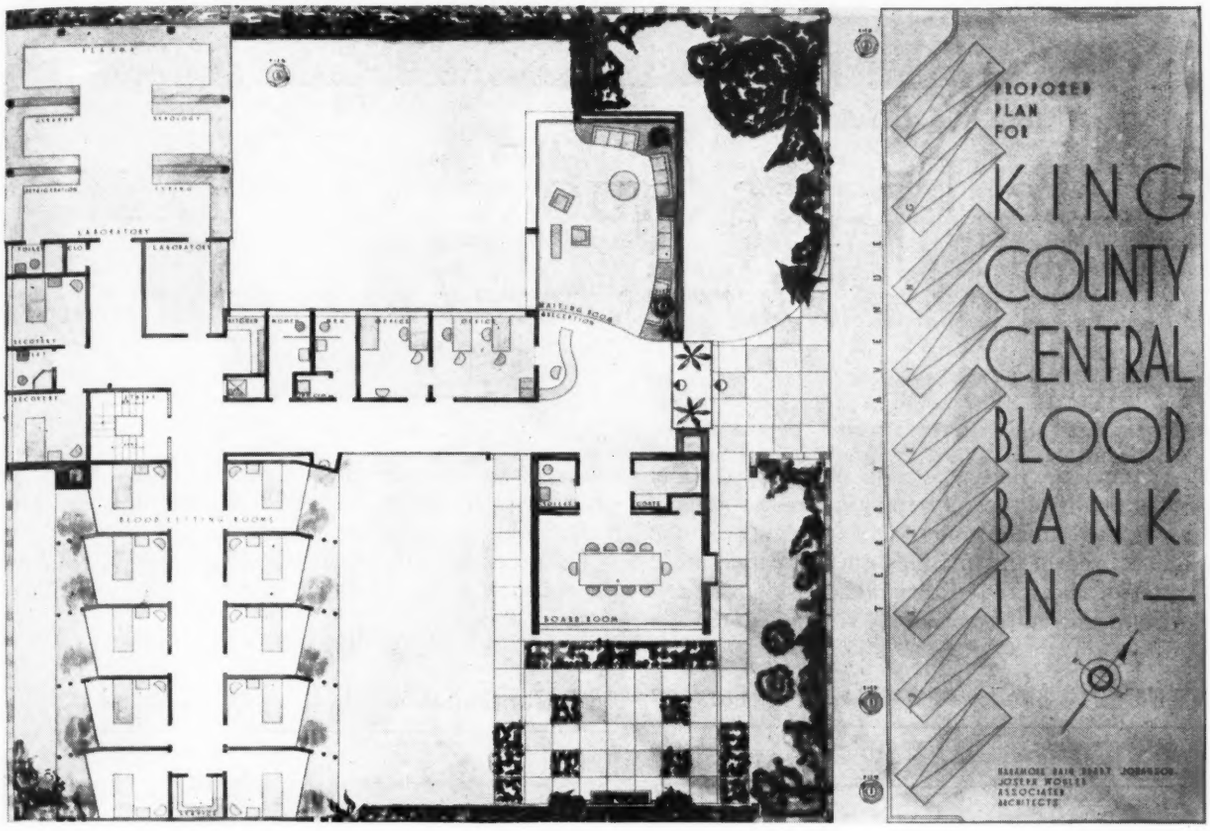
Main entrance looking toward the waiting room.

SEATTLE

WHEN Emil Sick, chairman of the March of Dimes infantile paralysis program for the state of Washington, owner of the Seattle baseball club and well-known Northwest philanthropist, decided that King County should have a community blood bank he went about it on a large scale.

After receiving the approval of the King County Medical Society, which appointed a group of doctors to assist in the technical aspects of the work, Mr. Sick's first move was to call upon 20 men, now known as the "founders group," and ask for donations of $5000 each toward the erection of the main building. The founders will be honored by having their names embossed upon a plaque to be placed in the main lobby of the completed building.

The second step was the donation by Dr. Manion Samuels, a Seattle physician, of a vacant downtown lot, valued at more than $50,000. A prominent firm of architects was employed as was the building and engi-



Builds a Blood Bank

A. J. HOCKETT, M.D.
Director, King County Hospital System, Seattle

neering firm that recently completed the world-famous Boeing plant. Both organizations have agreed to work on a nonprofit basis. Mr. Sick then launched a community campaign for the establishment of an endowment fund, looking toward future financial support. Organized labor contributed $25,000 and an additional $100,000 is now on hand for maintenance and future upkeep.

The King County Central Blood Bank has been organized with a board of trustees, with representatives from the King County Medical Society and more than 25 local organizations, which will direct its activities. Awaiting only material priorities for the construction of its permanent headquarters, the blood bank is now operating in temporary headquarters at the Harborview County Hospital, furnishing blood at a charge of $7.50 to all local civilian and military establishments.

Both whole blood and plasma are being furnished to all hospitals within a radius of 75 miles, as it is our experience that this is the approximate maximum distance for efficient operation. Organized labor has cooperated in furnishing thousands of donors to keep the blood bank replenished and the Yellow Cab Company is donating distribution service for blood, on a twenty-four hour basis, to all hospitals in the metropolitan area.

Some of the notable features of the plans are shown on the accompanying illustrations. The blood letting rooms have movable partitions (not shown) so that they can be converted into wards for large groups and private rooms for individual donors. It has been our experience that a better psychological attitude is obtained with large groups when bleeding is done in ward areas. Two recovery rooms are provided. It will also be noted that all laboratory and donor space is well screened from the public but that the main entrance is visible from the street.

A small apartment is included for employes who will necessarily be on duty twenty-four hours a day. Interiors will be finished in wood panels, with some marble, and the outside finishing will be of native stone. The roof is designed for future expansion should it be necessary. All laboratory space is to be air conditioned.

Adequate basement storage space with dumb-waiter service to laboratory areas on the second floor has been provided. This detail is often neglected in the building of blood banks and we believe it is an important item as supplies are bulky.

It is believed that this operation may well serve as a model of postwar planning for blood banks.

Where There's Smoke!

There is bound to be a problem

AILEEN M. HURLEY

NOT many administrators, of small hospitals at least, really approve of smoking in the hospital by patients, staff, nurses and visitors, judging by the 18 replies received to this month's questionnaire. Some of the respondents expressed their views with considerable asperity, while others are simply resigned to the fact that, cigaret shortage or no, the American public is determined to smoke anywhere at any time and provision must be made for it.

The accompanying tables tell their own story of how the situation is regarded and met by the administrators of these 18 hospitals.

1A—Should nurses be allowed to smoke in the hospital?

No—10	Yes (With Reservations)—7
1. No, not in hospital	1. In the nurses' dressing room, not on the floor or in patients' rooms.
2. No	2. Yes, not on duty.
3. No	3. I do not think so but as all the nurses do smoke I see no reason why they should not take time out to smoke once or twice a day, but only in nurses' dressing rooms.
4. No	4. I feel there is no objection to nurses' smoking in the hospital if they go to a room where patients and visitors will not see them and if they do not neglect their duties to do so.
5. No	5. Provided there is dressing or reception room in hospital.
6. No	6. Our nurses are allowed to smoke in the restroom if off duty.
7. No	7. Do not believe they should be allowed to smoke on duty but if they want to go to the nurses' dressing room smoking should be allowed there.
8. No, but we do	
9. Not while on duty	
10. No	

No answer—1

1B—Should they be allowed to smoke in the nurses' home?

Yes (With Reservations)—15

1. I don't believe we can or should try to restrict their smoking in the nurses' home.
2. Yes
3. There is a smoking room in the nurses' home and the resident nurses also smoke in their rooms.
4. I think it would be permissible.

1B—Continued

5. Yes
6. Yes
7. Yes
8. I feel nurses should be allowed to smoke in nurses' home. We do so here with no ill effects.
9. Yes
10. If they have a room to themselves or with an occupant who does not object.
11. I feel there is no objection.
12. Our nurses do smoke in nurses' home.
13. I feel that a room should be set aside for nurses who smoke instead of having them smoke in their rooms.
14. I have two graduates who smoke in their rooms.
15. In view of the times there seems to be no way of preventing this.

No answer—3

1C—If so, what restrictions should be enforced?

1. We ask them to be ladies.
2. I think there should be restrictions regarding smoking in rooms other than their own or the living rooms and parlor.
3. Limited to one comfortable room; safety, cleanliness and consideration of other smokers.
4. Not to smoke while in bed.
5. Not to smoke in uniform as they may carry odor to patients.
6. They must be clean in regard to disposing of cigaret butts and ashes.
7. One can only hope that nurses will be careful.

No answer—11

1D—Should the rules be different for students and graduates?

No—8	Yes—4
1. I don't think the rules should be different for students and graduates.	1. Yes
	2. My student nurses do not smoke. I do not accept any who smoke and if they take

1D—Continued

2. No
3. Students should be allowed just the same as graduates.
4. No, students may be allowed to smoke in residence.
5. No, both graduates and students smoke in the nurses' home.
6. No, but separate recreation room should be provided for students.
7. We frown on smoking by student nurses; however in recent years there have been no restrictions.
8. I see no reason for discrimination.

up the habit after entering the school they know they will be dismissed from the school. I have never had to expel any student yet.
3. I believe student nurses should be restricted, but how really to enforce such restrictions seems difficult.
4. Graduates are given a separate room and have later evening hours.

Other—2

1. The rule for student nurses rests with the school.
2. We have no training school.

No answer—4

2A—Should patients be allowed to smoke in the hospital?

No—4

1. No
2. They should not, but they do and will in spite of restrictions. Most patients smoke now.
3. Women patients, except when doctor requests or orders patient to smoke, should as far as possible be restricted from smoking.
4. Not in wards.

Yes—13

1. Yes, I believe patients should be allowed to smoke in the hospital.
2. Yes
3. Yes
4. There should be sunrooms or a smoking ward where patients who wish to smoke can be wheeled.
5. Convalescent patients are allowed to smoke.
6. In the present day it is almost necessary to allow patients to smoke in the hospital; however, we require a doctor's order before permitting this.
7. Patients should be allowed to smoke if they wish.
8. Patients are allowed to smoke with doors closed.
9. Yes
   Male patients, with doctors' permission. (3 in other column takes care of the women)
10. Convalescent patients are allowed to smoke.
11. Patients are allowed to smoke.
12. Patients who are able to handle cigarets carefully may smoke; others only if nurse or attendant is with them.
13. Yes

Other—1

1. Patients' smoking has not been a major problem with us. Perhaps we are too rural.

2B—If so, what provisions should be made for controlling the fire hazard?

1. Sufficient ash trays are provided and hours should be restricted as best suits the hospital. No smoking should be allowed at night.
2. Concrete construction. Ordinary care.
3. Patient must be fully capable of preventing fire. If they have narcotics we do not allow them to smoke. If any linen is burned we refuse permission to that patient for further smoking.
4. Special smoking room away from fire hazards.
5. Some one must be in ward or room to prevent fire.
6. As this is a very old frame building we caution our patients who smoke to be very careful.
7. Because our hospital is nearly 100 per cent fireproof we have never had a problem.
8. Patients in bed should report to nurse when smoking and definite stated hours only should be allowed in ward. We limit ward smoking to four times daily, half hour after meals and at bedtime.
9. No smoking allowed between 8 p.m. and 7 a.m.
10. If bed clothes are burned, the privilege of smoking is taken away.
11. Patients must be competent to handle cigarets carefully or else a nurse or attendant must be present to assist them.
12. A high ash tray on stand height of bed should be furnished.
13. No patient taking sedatives should be allowed to smoke.

No answer—5

2C—For preventing annoyance to other patients in wards or semiprivate rooms?

1. Depends on conditions.
2. If smoking annoys another patient in the room it should be discontinued.
3. When we have very sick patients in our semiprivate rooms or wards we ask the other patients not to smoke.
4. The nurse in charge should control smoking if annoyance to other patients.
5. Limited hours only in wards and then only if others do not object. We limit ward smoking to four times daily, half hour after meals and at bedtime.
6. Must not annoy other patients, else they cannot smoke.
7. If a patient in a semiprivate room objects, I believe this should be discussed with the other patient.
8. Courtesy.
9. If smoking annoys any of the patients in the semiprivate rooms, it is discontinued temporarily.
10. If we have a patient in a semiprivate room who doesn't smoke we move him in with another patient who doesn't smoke.
11. Must not annoy other patients.

No answer—7

3A—What are your views regarding smoking by physicians?

1. Try to stop them anywhere at any time!
2. Physicians are allowed to smoke in the hospital.
3. In my opinion it is all right for the physician to smoke.
4. This matter is entirely up to the physicians. They cannot, of course, smoke in operating room.
5. Physicians should be allowed to smoke in certain stated places.

3A—Continued

6. Our physicians smoke.
7. Doctors smoke.
8. Only one of our physicians smokes.
9. The doctors are permitted to smoke in the hospital.
10. Doctors should be allowed to smoke when and where they wish except in vicinity of gas machines, but occasionally this is forgotten and only a serious accident perhaps will make them conscious of this hazard.
11. The doctors smoke.
12. Should be allowed in doctors' room only.
13. I do not believe any restrictions should be made on doctors' smoking. Most of them are very considerate.
14. They may smoke.
15. Should smoke only in room provided for doctors, away from fire hazards.
16. It is all right provided they are careful.
17. We have no restrictions regarding physicians' smoking.

No answer—1

3B—May they smoke:

In doctors' lounge?	Corridors, public places?
Yes—17	**Yes—9**
1. Try to stop them	1. Try to stop them
2. Yes	2. Yes
3. Yes	3. Up to physician
4. Up to physician	4. Yes
5. Yes	5. Yes
6. Yes	6. Yes
7. Yes	7. Yes
8. Yes	8. Yes
9. Yes	9. Yes
10. Yes	**No—6**
11. Yes	1. No
12. Yes	2. No
13. Yes	3. No, but rule not always observed.
14. Yes	4. No
15. Yes	5. No
16. Yes	6. No
17. Yes	
No answer—2	

3C—If they are not allowed to smoke, how is the prohibition enforced?

1. Our physicians are usually quite cooperative under our plan of having smoking restricted to certain places in hospital.
2. By reminding them constantly.
3. The doctors are very cooperative in all of our undertakings to make our hospital more pleasant for all patients, hospital staff and employes.
4. Cannot offer any suggestions regarding enforcement of rules as we have no restrictions.

No answer—14

4A—Are visitors allowed to smoke:

In patients' rooms?

Yes—8	**No—10**
1. Yes, if not offensive to patients.	1. No
2. Yes, if not offensive.	2. No, but may if patient is smoking.
3. Yes	3. No
4. Yes	4. No
5. Yes	5. No
6. Yes, if not offensive to patients.	6. No
7. Yes	7. Should not be allowed.
8. Yes	8. No
	9. No
	10. No

In Waiting Rooms and Sun Rooms?

Yes—15	**No—3**
1. Yes	1. No
2. Yes	2. No
3. Yes	3. Should not be allowed.
4. Yes	
5. Yes	
6. Yes	
7. Yes	
8. Yes	
9. Yes	
10. Yes	
11. Yes	
12. Yes	
13. Yes	
14. Yes	
15. Waiting rooms but not sunrooms.	

5—What do you think about smoking in the dining room?

1. I believe no smoking should be allowed in dining rooms.
2. O.K. after meals.
3. Smoking is not allowed in our dining room.
4. I feel that it would be far better to permit the employes to smoke in the dining rooms if it could at all be arranged.
5. We allow the graduate nurses this privilege but not the students.
6. Do *not* approve. Further fire hazard, annoyance to kitchen and dining room workers; odor on all nurses when they go to their patients' bedsides. Too lax even in these times for continuance of good morale.
7. No.
8. It should be permitted.
9. We do not have any smoking in dining room.
10. We allow it.
11. Quite all right.
12. Not advisable in large hospital. In a small hospital where the personnel is all well acquainted, its likes and dislikes should be considered.
13. We don't like it but it is done.
14. Should be prohibited.
15. No.
16. Very ill manners. I have managed hospitals nineteen years out of twenty-six of my service and I have never allowed any nurse or doctor to smoke in the dining room. I just can't tolerate smoke in any space or by any profession. I never keep an ash tray in my office so, therefore, doctors and salesmen never offer to smoke as they do not see the ash tray.
17. Absolutely not, in our hospital at least. Restrooms are provided for our employes and if they must smoke let them do so there.
18. No, as others are in uniform who are on duty. Same with interns.

HEADLINE NEWS

General Bradley Is New Administrator of Veterans' Affairs

WASHINGTON, D. C.—General Omar N. Bradley has been appointed by President Truman to replace General Frank T. Hines as administrator of veterans' affairs. General Hines has served for twenty-two years. "I am accepting your resignation only because of a feeling which I have long held that the veterans of this war should have as the administrator of their affairs another veteran of this war," the President declared.

"By the time General Bradley's duties will enable him to assume office, the congressional investigation, which was begun at your own solicitation, will have been completed," the President added.

Meanwhile General Hines ordered a reclassification of nurses, social workers, dietitians and librarians in Veterans Administration facilities from subprofessional to professional status, effective July 1. Under the new arrangement nurses' salaries will range from $2000 to $4600 plus overtime and will place them on a par with their sisters in the Army, Navy or Public Health Service. In addition nurses are to be automatically rotated from isolated stations after two years. Dietitians will receive entrance salaries of $2000 and can go to $3800. Social workers will have an entrance salary of $2600 and will go up to $3800.

Construction Order Amended

WASHINGTON, D. C.—L-41, the construction order, amended May 29, has raised the allowance on permitted construction from $1000 to $10,000. It is not necessary to get War Production Board authorization under this order for construction jobs done on a unit if the total cost of all of the construction jobs begun on that unit in the same calendar year does not exceed $10,000. No authorization is necessary for any construction job up to $10,000 except for materials requiring priorities.

Petry Awarded Degrees

Lucile Petry, director of nurse education of the United States Public Health Service, was awarded a degree of doctor of humane letters by Adelphi College on June 6. On the next day at ceremonies dedicating a new school of nursing building at Syracuse University she was awarded a doctor of laws degree. Dr. Eduard C. Lindeman was the speaker at Adelphi.

Army Halts Nurse Recruiting; Drops Request for Nurse Draft

By EVA ADAMS CROSS

WASHINGTON, D. C.—Executing a sharp right-about face from its insistent appeals for nurses and still more nurses, the Army surgeon general's office called a halt to the recruiting of nurses until further notice, according to an announcement of the American Red Cross, official recruiting agency, June 3. The halt came swiftly on the heels of the War Department's dropping of its demand for a nurse draft law.

The directive from national headquarters here said, in part: "The changing war situation, the unprecedented response of nurses since the first of the year, together with the participation of a full complement of Army senior nursing cadets, have relieved the critical nursing situation in Army hospitals at a somewhat earlier date than was originally anticipated." The Army Nurse Corps now has enough nurses to assure adequate care for wounded and sick soldiers.

Sen. Elbert D. Thomas was quick to comply with Acting Secretary of War Patterson's request to drop further action on the nurse draft bill, H.R. 2277. The response of the nurses to the appeal has been most patriotic, said Mr. Patterson. Voluntary recruiting of nurses in addition to the efforts of the Red Cross and Procurement and Assignment Service for Nurses had been aided, he declared, by the campaign instituted in April by the American Nurses' Association.

Cadet Recruiting to Be Intensified, Parran Asserts

WASHINGTON, D. C.—In spite of the Army's discontinuance of nurse enlistments, the cadet nurse corps must intensify its recruitment of student nurses for summer and fall classes to meet civilian health needs, Dr. Thomas Parran, surgeon general, U.S.P.H.S., stated on June 13.

At the present time the Army expects to fill future needs from senior cadets assigned to Army hospitals who will volunteer to join the Army Nurse Corps, Doctor Parran pointed out. "To maintain the flow of senior cadets into Army service, it is imperative to keep recruitment at high levels," he continued. "Equally important is the contribution cadet nurses have made in preventing the collapse of civilian nursing. We must continue to prepare nurses for needs in fields of nursing where the demand is expanding, especially the care of veterans."

Attractive promotional material has been prepared for the program.

1945 Tri-State Meeting Off

The 1945 meeting of the Tri-State Hospital Assembly which was scheduled to be held July 18, 19 and 20 has been officially canceled. Reservations have been made with the Palmer House, Chicago, for the 1946 meeting to be held May 1, 2 and 3.

Overseas Nurses to Come Home

WASHINGTON, D. C.—A vigorous program is under way to bring home the nurses who have already had long and arduous service in the Pacific and Asiatic theaters for replacement by rotation, Acting Secretary of War Robert P. Patterson said May 25 in a letter to Sen. Elbert D. Thomas, chairman, committee on military affairs. The only limitation on this program now is the critical shipping situations during the redeployment period, he continued. This situation may result in holding temporarily in this country some nurses intended for use as replacements. But the existence of this group, he pointed out, made possible only by the recruiting campaign of recent months, will enable the Army to bring home at the earliest possible date the nurses who have had long overseas duty.

Introduce Dental Aid Bill

WASHINGTON, D. C.—Introduced on June 4 by Senator Pepper and Senator Aiken was a bill providing financial aid to states and municipalities for prevention and treatment of dental diseases. The bill would provide funds to states, municipalities, educational institutions and other nonprofit agencies for studies and demonstration programs in dental care, administrative practices in dental health and development of new methods of payment for dental services. It would also train personnel for dental health work.

A.H.A. Adopts Veterans' Committee Report; Urges Free Choice of Physicians

The veterans of this war should have the opportunity to receive their medical and hospital care in their own communities and from doctors and hospitals of their own choice, at least insofar as short-term illnesses are concerned, the A.H.A. trustees stated at their meeting on June 15 and 16. The trustees adopted a report of the committee on veterans' relations.

The A.H.A. interest in this problem is particularly that "the best in hospital and medical care be available for the largest number of veterans," according to the statement. The association believes "that a method can be developed which will not only permit an improvement in hospital care for veterans at a cost comparable to experience in providing these benefits in the past but will also strengthen and benefit the whole hospital system of the country."

Under the seven-point A.H.A. program the federal government would continue responsibility for financing hospital and medical care for service-connected disabilities for all veterans and for nonservice-connected disabilities when veterans are unable to meet that expense. Insofar as possible the federal government would avoid the construction of a large number of additional general hospitals and instead would emphasize the development of community hospitals available to all.

Veterans would be given free choice of hospital and medical care in either federal or nonfederal hospitals or outpatient departments for treatment of short-term illnesses and hospitals and doctors would be reimbursed on an equitable basis for this care.

Those veterans receiving treatment in nonfederal hospitals for nonservice-connected disabilities because of inability to pay would be permitted to make their own arrangements with private physicians or hospital staffs but could also choose a veterans' facility.

Testimony by the American Legion and the Veterans of Foreign Wars before the House veterans' committee on June 12 indicated that some facilities investigated by these organizations provided excellent treatment while others were at a low level.

The recommendations of both organizations included increased bed capacity and provision for women patients; higher wage scales; more authority for local officials to employ professional personnel and procure supplies, provisions for research and professional stimulation; expansion of rehabilitation and recreational programs; more intelligent segregation of patients by clinical classification; removal of administrative detail from doctors; better counseling services to veterans; better personnel training programs; swift handling of complaints, and replacement of Army personnel with civilians.

Judd Bill Seeks Release of Doctors From Services

WASHINGTON, D. C.—On May 29 Representative Judd introduced a bill similar to others recently introduced to authorize the release or deferment of persons from military service in order to aid in making possible the education and training of physicians and dentists to meet essential needs.

To the extent that it is feasible and compatible with military operations, the release is asked of as many persons as are necessary to provide the minimum number of medical doctors and dentists required to meet the essential needs of the civilian population, especially in rural areas, and the armed forces for medical and dental services to be rendered in the future.

Representatives of the committee on postwar medical service have called on President Truman to present a memorandum dealing with the supply of premedical and medical students and physicians. The memorandum stressed the growing need for physicians by the civilian population, the Veterans Administration and the armed forces. With the diminishing number of admissions of freshmen to medical schools, the need for well-trained medical men will become more acute.

Washington Board Named

Prof. C.-E. A. Winslow, Col. Ira V. Hiscock and Dr. Claude W. Munger have been named as the board of surveyors to direct the coming health and hospital survey sponsored by the Washington Metropolitan Health Council, Washington, D. C., a division of the Council of Social Agencies. V/A Ross T. McIntire, surgeon general of the Navy, has been made chairman of the survey committee. The survey is expected to be completed within four months starting September 1 and will involve a study of facilities and activities of health agencies, hospitals and clinics, both public and private, in the metropolitan area of Washington.

Urge More Money to Expand Program of Child Health Care

By EVA ADAMS CROSS

WASHINGTON, D. C.—For the fiscal year 1946 federal funds for grants to state health departments for maternal and child health should be raised by $50,000,000, the National Commission on Children in War Time urged in a report to President Truman, according to an announcement June 17 by former Secretary of Labor Perkins. The present appropriation is $6,000,000. The raise called for was broken down as follows: maternity care and care for infants and preschool children, $25,000,000; preventive and curative health service for children of school age, $15,000,000; dental care of young school children, $10,000,000.

For the fiscal year, 1946, the maximum authorized for appropriation from federal funds for crippled children's services, now less than $4,000,000, should be raised by at least $25,000,000, the report continued. This sum, as broken down, follows: orthopedically crippled children, including children with cerebral palsy, $5,000,000; children with other physically handicapping conditions, including defects of vision and hearing and diabetes, $5,000,000; children with rheumatic fever and heart disease, $15,000,000.

Federal legislative action should provide now for immediate needs of mothers and children, the report stated. Special emphasis should be put on developing adequate health center, clinic and hospital care for maternity patients and new-born infants, and for older infants and children.

An additional $2,200,000 has been approved by both houses of Congress to provide medical, nursing and hospital maternity and infant care in the E.M.I.C. program during the remainder of the present fiscal year ending June 30. The regular appropriation bill for the forthcoming fiscal year calls for $44,189,500 for this program.

Six Nurses Killed on Ship

WASHINGTON, D. C.—Six Army nurses were killed aboard the hospital ship, the *U.S.S. Comfort,* according to an announcement of the War Department May 30. Since Pearl Harbor 157 nurses have been killed.

Killed were: Lt. (2d) Margaret M. Billings, Lt. (2d) Frances O. Chesley, Lt. (1st) Florence T. Grewer, Lt. (1st) Ida M. Greenwood, Lt. (1st) Dorothy M. Stanke and Lt. (2d) Evelyn C. Eckert.

Three Bills Pending on Medical Bureau for Veterans Administration

By EVA ADAMS CROSS

WASHINGTON, D. C.—Three bills, the most recent one introduced being that of Senator Johnson of Colorado on June 1, to establish a department or bureau of medicine and surgery in the Veterans Administration are now pending in Congress. S. 1079, Senator Johnson's bill, is identical with Mr. Rankin's, H.R. 3310, introduced May 25. Mrs. Rogers' bill, H.R. 3317, also introduced May 25, is similar to the other two, though not identical. A quick reading of the three bills indicates that there are no essential differences. There is considerable difference in Mrs. Rogers' present bill and H.R. 1661, which she introduced in January.

All three bills would establish in the Veterans Administration a department of medicine and surgery under a surgeon general. The functions of the department shall be those necessary for a complete medical and hospital service to be prescribed by the Administrator of Veterans Affairs. It would include the following: medical corps, dental corps, nurse corps and administrative corps (including laboratory technicians, therapists in physical medicine, pharmacists, dietitians, librarians, social workers and supply and maintenance).

No action has to date been taken on any of the bills. Mr. Rankin's and Mrs. Rogers' have been referred to the committee on world war veterans' legislation and Senator Johnson's, to the Senate committee on finance.

A.M.A. Protests Bill

The Rankin Bill was condemned in an editorial in the issue of June 2 of the *Journal of the American Medical Association* because it does not give "any consideration to the rights of the men involved." The *Journal* editorial states that under the terms of the bill commissioned and noncommissioned personnel of the Army and Navy may be detailed for service with the Veterans Administration, and also that members of the department to be created are exempt from selection or draft for service with any other component of the armed forces but that any personnel needs of the department may be filled by assignment of selected or drafted persons.

Such a proposal, the editorial contends, would make it possible for physicians, at least during war time, who have enlisted in the armed forces to be drafted into the Veterans Administration.

The A.M.A. expects that its vigorous protest against this provision of the bill will be effective.

Army Considers Civilian Needs in Fixing Medical Personnel Policy

By EVA ADAMS CROSS

WASHINGTON, D. C.—Consideration was given to civilian needs for professional medical and dental care, Maj. Gen. Norman T. Kirk said May 31, in formulating the policy of medical department personnel releases. No substantial releases will take place, however, before the latter part of the year, he said, because the peak of the medical department's activities will not be reached until fall. The personnel release policy applies with equal effect to Army medical officers assigned to the Veterans Administration and other agencies.

For the *medical corps,* the policy reads: Officers whose services are essential to military necessity will not be separated from the service. Officers above 50 years of age whose specialist qualifications are not needed within the Army will receive a high preferential priority for release from active duty. Adjusted service ratings will be utilized as a definite guide to determining those who are to be separated.

For the *medical administrative corps,* the policy follows: Officers whose services are essential to military necessity will not be separated. Officers who express a desire to stay on duty shall be allowed to do so if vacancies exist. In the event there are more officers wishing to stay than there are vacancies, those with the highest efficiency index will be retained. Those who wish to be released will be selected on the basis of adjusted service scores.

For the *army nurse corps,* the policy advises: All nurses whose husbands have been released from active duty will be discharged upon request when release of husband is proved. No officer will be separated whose services are essential. Officers with children under 18 years of age who wish to be released will receive a high preferential priority for selection. Adjusted service scores will govern other cases.

For *medical department dietitians and physical therapists,* the policy reads: All medical department dietitians and physical therapists whose husbands have been released from active duty will be discharged upon request when release of husband is proved. Military necessity will govern all others. Since there is a shortage of these officers, it is not contemplated that others will be released except in the instance cited above.

In spite of General Kirk's statement, Sen. Sheridan Downey of California asked Congress June 12 to make an investigation of the relative needs of civilians and the armed forces along this line. S.R. 134 asks that the Committee on Military Affairs or any duly authorized subcommittee make a complete investigation with respect to the relative needs of the armed forces and civilians for the services of medical personnel.

House Approves Appropriations for Public Health Service

WASHINGTON, D. C.—Hearings on the House-approved H.R. 3199, the Labor-Federal Security Appropriation Bill, 1946, which includes appropriations for the U. S. Public Health Service, were slated for the week beginning June 11, according to a spokesman of the Senate Appropriations Committee.

If the Senate proposes amendments to the bill, it will have to be returned to the House for action on such amendments. Differences on the bill will then be submitted to a joint conference committee of the House and Senate.

Among House-approved appropriations for the Public Health Service are the following: venereal disease control, $11,949,000; tuberculosis control, $6,047,000; assistance to states, general, $11,467,000; communicable disease control, $1,040,000 (an increase of $684,000); malaria and diseases of tropical origin, $10,897,000; hospitals and medical care, $15,501,300; training for nurses, $59,957,000; National Cancer Institute, $490,000; postwar planning, $317,000.

Louis Pink Serves Philippine Government as Insurance Adviser

In response to a personal appeal from President Sergio Osmena of the Philippine Islands, Louis H. Pink, president of the Associated Hospital Service of New York and former superintendent of insurance of the state of New York, has been given a leave of absence until September to serve the Philippine government as a special adviser in reorganizing the insurance industry of the Philippines.

Mr. Pink will direct the insurance companies' return to orderly operations as well as protect the interests of the citizens. In 1943, Mr. Pink was granted a leave of absence to aid the government in instituting rent control in New York City.

TRUSTEE FORUM

CONDUCTED BY RAYMOND P. SLOAN

The Question of Personnel

DAVID M. FREUDENTHAL
Trustee
Chairman, Personnel Committee
Montefiore Hospital, New York City

HOSPITAL trustees, it appears, are recognizing that hospitals, like industry, have their personnel problems. This fact by itself is encouraging and holds much promise for better employer-employe relations in hospitals in the future. What is of even greater significance, they are beginning to find some parallel between personnel practices in business and in hospitals.

Heretofore, the hospital rank and file employe has been an unknown quantity to many trustees. That he frequently lives somewhere in the building, that he is given food, uniforms and lodging in addition to his wage, that he performs certain functions is the extent of their knowledge. Their astonishment is easily explainable, therefore, when presented with budget figures for the new year, to find that salaries have jumped considerably. Such a condition is understood in industry but hospitals are or were different, it was always supposed.

They Aren't So Different

This is where the trustee has been permitted to labor under false impressions. Hospital operation is not so different from business operation, at least not with respect to personnel management. Hospitals constitute, in fact, one of our biggest industries.

Consequently, why not apply some of the lessons we have learned from personnel practice in business to the hospital? Some of these practices may prove successful; others not. It is worth the attempt anyway because we now recognize that as a rule a good place to work is most likely to be a well-conducted institution.

What may be attributed as indifference on the part of the trustee in personnel matters is not necessarily that but, instead, a lack of information or facts. Take the matter of salary increases, for example. How is he to judge whether the wage scale of his own institution is in line with others?

This might be accomplished by having requests for wage increases emanate from the department head, follow a logical course through the office of the personnel director and, having passed over the administrator's desk, reach the chairman of the division in which the employe works and thence to the chairman of the personnel committee in order that he may be informed. The chairman could then intelligently interpret to the board any increase in salaries as they appear on the budget. Also, should there be any inclination to take too hasty action he is prepared to inject a note of warning: "You people have approved increases; here is what is involved in cash."

Such discussion is based on a report of the personnel director or the superintendent, in the event that the institution is not large enough to warrant someone's handling personnel exclusively, who has obtained comparative wage scales in other organizations and institutions. This proves an equitable way to keep hospital salaries in line.

Any carefully conceived personnel plan should include some award for long-term service. Whether it is a pin or service stripes or a suitably engraved scroll makes little difference so long as the recognition is made publicly. The faithful employe should be accorded the honor of a formal presentation of his award.

The greatest step toward better hospital personnel relations, in my opinion, would be to eliminate to whatever extent is practicable the custom of "living in." The hospital employe should be given a wage comparable to that received by others doing similar work in the community and be permitted to live where and as he pleases. People don't like to be regimented. Fortunately, there is a trend in this direction, I am told. It is going to cost more money, of this there can be little doubt, but we must face that situation somehow. Many of our institutions, unfortunately, have been designed to provide accommodations for housing personnel. Undoubtedly, with the increasing demands for hospital space these quarters can be diverted to other uses.

Must Include Training Program

It is inconceivable that personnel programs in the future should not include greater provision for training. I suspect that few hospital jobs have been manualized. Yet the simplest job in industry is reduced to writing. A continuity in performance is assured through the manualization of various operations, such as washing floors, for example, and cleaning windows, the value of which cannot be denied. Manualization where presently employed should be extended.

Because hospital services require a special technic it would seem wise to hold group meetings of employes so that they may be informed how to conduct themselves in their contact with sick people. Whether this can be accomplished better through individual department meetings or by general conferences is a detail that must be decided individually. The important point is to furnish some sort of training.

While on the subject of training it is evident that much remains to be accomplished in elevating standards for hospital orderlies. What Florence Nightingale did for the nursing profession someone should do for the profession of the orderly,

Pete Pyrogen is mad as sin!
Bite, hack, or claw — he can't get in
A Cutter Saftiflask, that's sure —
They're built to keep solutions pure!
Far better judgment he'd have shown
To stick with folks who "mix their own!"

GET THIS EXTRA SAFETY AT A SAVING ... SWITCH TO CUTTER *Saftiflask Solutions*

- With Cutter Saftiflasks, you get the benefit of elaborate safety precautions that would send your own expenses rocketing out of sight. Physiological tests, bacterial tests — tests absolutely essential and routine in a biological laboratory for the testing of delicate vaccines and antitoxins.
- Think what this means to you and your staff. Our rabbits get the reactions, not your patients. And your hospital gets this added protection at *no extra cost!*
- In addition, your staff enjoys the convenience of truly sensible equipment. No loose, tricky parts to wash and sterilize—no time-consuming gadgets to delay a vital "I. V."
- We suggest you contact your Cutter distributor, and use Saftiflasks — *from now on!*

CUTTER
Fine Biologicals and
Pharmaceutical Specialties

CUTTER LABORATORIES • BERKELEY • CHICAGO • NEW YORK

for he is, after all, a practical nurse. Suitable courses of training with recognized professional standards and proper selectivity in applicants constitute a definite challenge.

The presence of a personnel director is essential to the organization and fulfillment of any sizable personnel relations program. When the size of the institution does not warrant a full-time director, it is possible that the responsibility may be turned over to someone in combination with other duties. The point is that someone, somehow, must serve in such a capacity.

The first responsibility of the personnel director should be to see that wage scales are equitable. It should not be the individual who is merely vocal who receives recognition. Advancement should be based on performance rather than impressions. For this reason the personnel director should work closely with department heads to obtain and study performance records. This can be accomplished without in any way abrogating the importance of the department head. In the course of such study it is likely that considerable corrective work must be done.

Twice every year, if possible, the performance of every individual should be reviewed with the department head. And it is highly important that the individual know that this review is being made. If he is conscious that his progress is being watched and that someone is paying atention to him he will put forth his best effort. Otherwise he feels lost and loses interest and ambition.

The results of these reviews can take the form of either a formal interview with the individual in the presence of the department head or, if it seems best, merely an informal conversation. Frequently, the latter procedure is more successful. In either event the personnel director should get around the building and talk to the employes, preferably on subjects quite remote from their work. In so doing he can get to know them and discover their problems and difficulties.

We are hearing more and more about pension plans. Certainly there is need for them in hospitals. It is the only adequate form of reward and security for long-term service. Again the question of expense must be considered, of course.

What the hospital trustee needs to recognize more than anything else about hospital personnel programs is that they will cost more money. The sooner he accepts this fact and takes steps to provide for it, the better.

Hospital wages in future will and must more nearly approximate those paid for similar work by other organizations in the immediate community. And from the standpoint of management, this is as it should be because, as is generally known, better personnel will turn in better performances. Hospitals, as is true with every other business operation, will get better production from fewer people.

Question of the Month

QUESTION: Should the hospital trustee be expected to attend meetings of other hospital groups, local, national or both? Or is it sufficient that he confine his activities to his own board and committee meetings? Frequently it is difficult to find time to do even that. I should appreciate your thoughts on this point as it has been raised on several occasions within our group.—F.P.T.

ANSWER: In proportion as hospitals assume their proper function as part of a comprehensive community health program, it is essential that their trustees broaden their own vision and interpretation of hospital and health service. To accomplish this they must familiarize themselves not only with their own hospital's services but with the work of other local and national agencies to assure the necessary coordination. Isolationism no longer has a place in modern health planning.

This change in attitude demands more of the trustee, to be sure. It will automatically eliminate some who are now serving and will create higher standards for hospital stewardship generally. It may eventually require a revision of by-laws by some institutions reducing the number of board members, a procedure that has long been advocated in these columns.

No, it is impossible to visualize a competent hospital trustee who does not step out of his local picture occasionally and learn at first hand of what others are doing and along what lines they are thinking. Busy men and women cannot always take time to travel considerable distances to attend hospital meetings, to be sure, but it is not too much to expect that every hospital board become actively identified with local hospital councils and similar groups, also that one member at least be appointed to represent his hospital at meetings of our national hospital association.

Any doubts that such procedure will prove beneficial to the individual as well as to the institution will be dispelled by reading the report made by Grant G. Simmons to his fellow members on the board of Greenwich Hospital, Greenwich, Conn., following his return from the American Hospital Association meeting in Cleveland in 1944, which was reproduced in these pages in December 1944.

Hospital conventions and meetings, like others, are subject to the ruling of the Office of Defense Transportation. When the ban is lifted, let's see more hospital trustees at these events and hear them raise their voices with others in behalf of our voluntary agencies.

VOLUNTEER ACTIVITIES

About Hansen's Disease

Most women's service groups arrange several meetings during the year at which staff doctors or outside speakers give talks on medical or health subjects. How about getting a speaker for your auxiliary to bring you up to date on Hansen's Disease? The women's auxiliary of the Easton Baton Rouge Parish Medical Society in Louisiana recently heard Dr. George L. Fite speak on the subject. Doctor Fite is resident pathologist at the National Leprosarium, Carville, La.

Dr. F. C. Lendrum of the University of Illinois College of Medicine is another interesting speaker on Hansen's Disease. Or, have one of your own members brush up on the subject for once you hear about it, you become a crusader. For lepers suffer more from the word "leprosy" than they do from the disease and it is all because of an erroneous translation of the Old Testament. Hansen's Disease is the modern term.

In Favor of Favors

The war has not done away with holiday tray favors at Mercy Hospital of Hamilton, Ohio. When the Campfire Girls are not providing them for Easter, the Holiday Tray Circle (yes, that's its sole purpose) of the Service League is turning out Memorial Day favors or thinking up an original idea for the Fourth of July.

A DEPENDABLE SOURCE OF SUPPLY.

DAY BY DAY the use of penicillin is expanding. As the medical profession recognizes its superiority in the management of a given condition, its use in this indication becomes standard procedure. Hence a dependable source of supply becomes important.

Penicillin-C.S.C. with its production capacity of ONE MILLION VIALS PER MONTH, 100,000 Oxford Units each, assures dependability of supply. Its reliable potency, nontoxicity, and freedom from pyrogens, safeguarded by bacteriologic and biologic assays, assure the physician's satisfaction.

Penicillin-C.S.C. is supplied as such and in combination packages providing 100,000 O.U. of Penicillin-C.S.C. and 20 cc. of sterile, pyrogen-free isotonic solution of sodium chloride.

CSC

PHARMACEUTICAL DIVISION

COMMERCIAL SOLVENTS *Corporation*

17 East 42nd Street New York 17, N. Y.

ACCEPTED AMERICAN MEDICAL ASSN

Penicillin-C.S.C. stands accepted by the Council on Pharmacy and Chemistry of the American Medical Association.

PENICILLIN-C.S.C.

A General Hospital's Report on Poliomyelitis

A. J. McRAE, M.D.
Superintendent, Meadowbrook Hospital, Hempstead, N. Y.

THE number of cases of acute anterior poliomyelitis in the United States in 1944, more than 19,000 according to the U. S. Public Health Service, was exceeded only in the epidemic of 1916. Nassau County reported 220 of the 6391 cases of infantile paralysis that occurred in New York State in 1944, a case rate of 48.4 per hundred thousand.

Poliomyelitis occurs in Nassau County, New York, with more or less frequency, every summer and fall. In the years 1935 to 1943, inclusive, 167 cases of infantile paralysis were treated in Meadowbrook Hospital, the county's general hospital.

Nassau County's first case in the 1944 epidemic of poliomyelitis was admitted to Meadowbrook Hospital on June 26. In July, six more cases entered the hospital; the number increased rapidly in August and September, and the last patient was admitted in December. More than 75 per cent of all the admissions for poliomyelitis were during the months of August and September.

Call Meeting to Discuss Problem

In midsummer it was apparent that the epidemic had become serious and, on August 18, a special meeting of the county medical society, which was held at the hospital, was attended by nearly 100 members of the society, nurses, officials of the county health department, representatives of the press and others. The epidemiology, diagnosis and treatment of poliomyelitis were discussed by the director of the division of communicable diseases of the New York State Department of Health, members of the staff of the Willard Parker Hospital of New York City, the county health commission and the chief of the hospital's orthopedic service. The chairman of the local chapter of the National Foundation for Infantile Paralysis promised the assistance and cooperation of that organization.

All the hospitalized cases of poliomyelitis in the county were sent to Meadowbrook, the only hospital in the county for communicable diseases. The hospital had 27 beds in its contagious disease building and ample provision for convalescents. When the epidemic started, the hospital had three respirators and two more were provided by the local chapter of the infantile paralysis foundation.

Except for a few private cases, all the patients having poliomyelitis were admitted to the medical and pediatric services as staff cases and, on discharge from the hospital, were examined by the chief of the orthopedic service who determined the amount of disability. Discharged patients, with the consent of their family physicians, were followed up in their homes by public health nurses and returned to the hospital at regular intervals for examination. In one or two instances paralysis appeared after the patient's discharge from the hospital.

The Kenny method of treating poliomyelitis has been used here since 1941 when Sister Kenny visited the hospital. This technic requires the services of many nurses as the hot packs have to be applied day and night. It was quickly seen that the hospital's nursing staff, which had been reduced more than 50 per cent in the past few years, could care for only a limited number of patients. A few county health nurses, who had been given special training in the Kenny technic, were assigned temporarily to the hospital.

The epidemic gave the cadet nurses of the Adelphi College School of Nursing, affiliated with the hospital, ample experience in the nursing of infantile paralysis cases. The Nassau County chapter of the National Foundation for Infantile Paralysis obtained a physical therapist for the hospital and recruited and paid for the services of special nurses, thus assuring adequate nursing care for all poliomyelitis patients.

Diagnosis Correct in 171 Cases

The diagnosis of poliomyelitis was found to be correct in 171 of the 216 patients sent to the hospital. On observation, the other cases proved to be either upper respiratory infections, tonsillitis, meningitis, gastroenteritis, osteomyelitis, otitis media, pneumonia, pleurisy, subarachnoid hemorrhage, cardiac disease, brain tumor, phlebitis, hysteria or epilepsy. All of these patients had symptoms suggestive of poliomyelitis when first seen and the fact that they were referred to the hospital showed that the physicians of the county were poliomyelitis-conscious.

It would appear that the occurrence of infantile paralysis is comparatively rare among Negroes as there were only four colored patients admitted, the same proportion as in the 1935 epidemic.

The poliomyelitis patients came to the hospital from all parts of the county. In some instances, it was apparent from the history that the disease was contracted outside of Nassau, and a few of the patients were from an adjoining county. A young woman was admitted who had come to Long Island from Pennsylvania to convalesce following tonsillectomy and developed poliomyelitis fourteen days after this operation. During the epidemic, ton-

Meadowbrook Hospital gratefully acknowledges the assistance of the Nassau County chapter of the National Foundation for Infantile Paralysis, Inc., in providing special nurses and supplying equipment; the cooperation of the county health department in sending public health nurses to the aid of the hospital, and the help of the women's auxiliary of the county medical society whose members served as receptionists during the epidemic.

sillectomy was generally discontinued throughout the county.

In age, the patients ranged from eight months to 38 years, six were two years or under and 87 per cent were less than 20 years old. The greatest incidence of the disease occurred in the 5 to 10 year group, a total of 58 cases, or 33.5 per cent.

Two of the patients were pregnant. One 24 year old woman, eight months pregnant, had to be placed in a respirator. The advisability of cesarean section was being considered and while the intern was listening to the fetal heart the patient died. The intern promptly proceeded to do the section and extracted a premature baby, who was discharged from the hospital three weeks later in good condition.

Three of the seven patients placed in respirators died. The use of the respirator was delayed as long as possible and the patients were taken out at the earliest moment. At one time four respirators were in use.

The diagnosis of infantile paralysis was made on the basis of the history and symptoms, physical examination and laboratory findings. A careful physical examination of each patient was made on admission with particular attention to stiffness of the neck and spine, spasm and the presence of weakness or paralysis. A spinal tap was done on practically all patients and, in some cases, many taps were necessary before a definite diagnosis could be made. In 86 per cent of the patients, the spinal fluid showed 10 or more cells.

In addition to the Kenny therapy, the patients were given routine nursing care, fracture boards and foot boards when necessary and plaster casts or splints as indicated. An amendment to the state sanitary code, permitting the discharge of poliomyelitis patients at the end of the febrile period, shortened the patients' hospitalization considerably, and the average length of stay in the hospital for all cases was ten days.

The number of patients discharged as cured was 71. Of the other patients discharged, 59 had paresis and 33 had varying degrees of paralysis. The hospital transferred 20 patients with extensive paralysis to the State Convalescent Hospital at West Haverstraw.

Comparison of the 171 cases hospitalized in 1944 with the 81 cases in 1935 shows practically the same death rate in the two epidemics, eight deaths in 1944 and four in 1935. All the eight patients who died had the bulbar or ascending type of the disease. Two necropsies were performed and cord sections showed the classical pathology of infantile paralysis.

No cases of cross-infection occurred in the hospital. Early in the epidemic, a young woman employed as a nurse's aide in the children's department developed the disease which caused considerable worry. Four of the hospital's 65 cadet nurses and one of their instructors had poliomyelitis. One of these cadets worked in the contagious disease building for one day before becoming sick and another had been nursing convalescent patients.

This experience at Meadowbrook Hospital with infantile paralysis demonstrates that a general hospital, even in war time, can successfully treat the many victims of an epidemic, such as occurred in 1944, without danger to other patients or to the hospital personnel.

Clinical Uses of Curare

EDGAR T. BEDDINGFIELD

Department of Pharmacology, University of North Carolina

CURARE was first introduced to the scientific world in 1595 by Sir Walter Raleigh, who obtained specimens of it from the Orinoco Indians and returned them to England with other curiosities from the New World. He described its use as an arrow poison by the Indians and although it was generally known that the curare action was of a paralytic nature, causing death by respiratory paralysis, the exact mode of action was not investigated until many years later.

The classical experiments of Claude Bernard in 1840 showed that in a muscle-nerve preparation in a curarized frog the muscle, although contracting when stimulated directly, showed no response to stimulation of the nerve. He concluded, quite correctly, that the curare effect consists of the interruption of nerve impulses at the myoneural junction. Further investigations by Langley into the site of action have shown that curare continues to act even after the motor endplate has lost its function. The action might, therefore, be said to be exerted not on the endplate but on the "receptor substance" that serves to transfer the nerve impulse from the endplate to the contractile tissue of the muscle. This inhibitory action is reversible, normal function returning when the curare disappears from the circulation.

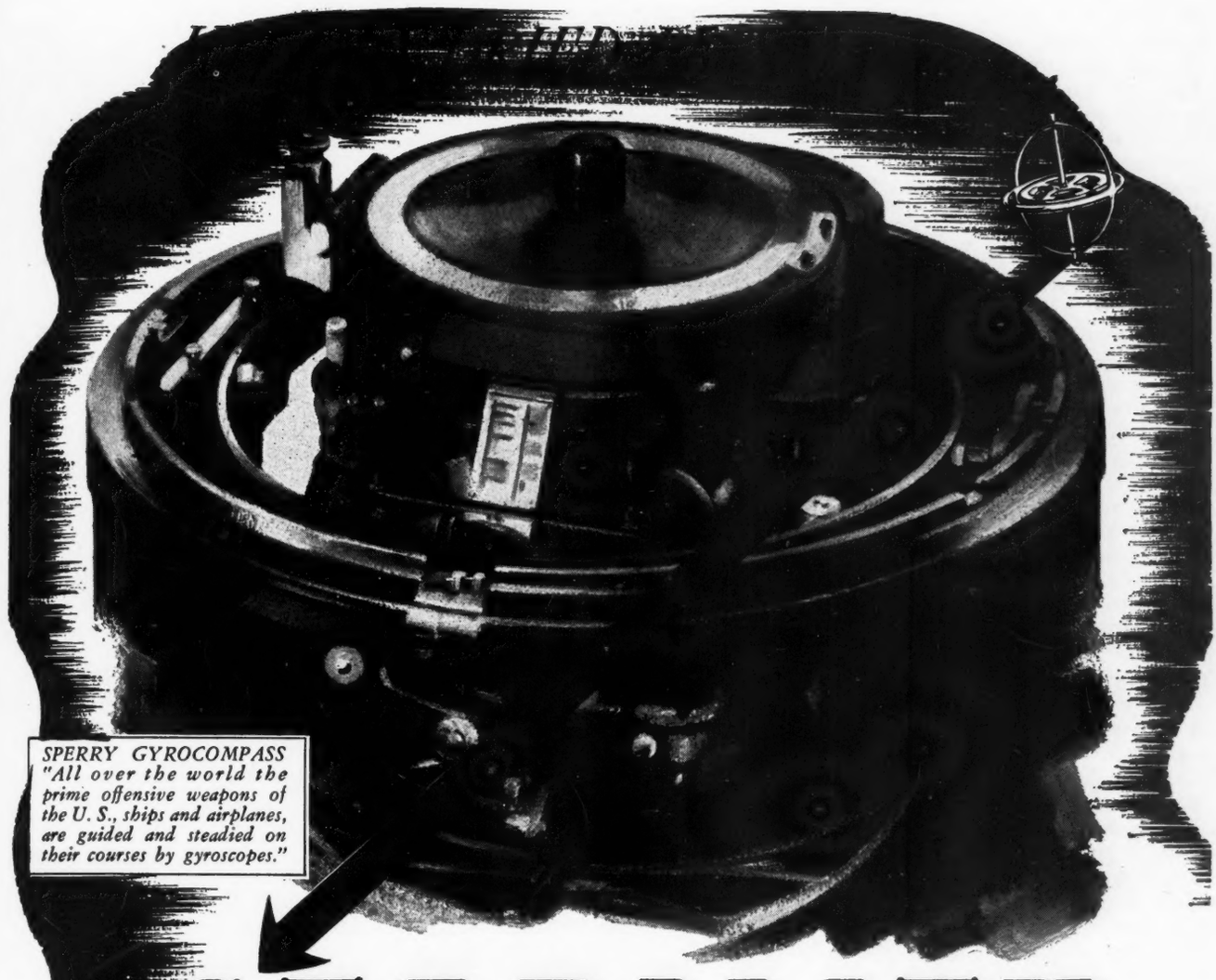
Always fascinating to the clinician because of this specificity of action, only recently has curare come into its own as a useful therapeutic agent. This may be attributed in large measure to the uncertainty as to content and dosage of the various forms of the agent as prepared by the South American Indians. They obtained it by various extractive processes from the root and bark of several species of *Strychnos*.

The recent development of a purified and standardized curare preparation which can be accurately assayed by physiologic methods has lent itself to rapid progress in therapeutic investigation.

Application in Surgery. To date, the most widespread and practical use of curare has been as an agent to facilitate muscular relaxation as an adjunct to surgical anesthesia. Other important uses also will be considered. Every surgeon is cognizant of the desirability of achieving a state of complete muscular relaxation in many types of operations, especially those in the abdominal cavity. Too often this relaxation has of necessity been attained by increasing the concentration of the anesthetic employed to levels generally considered unsafe.

The controlled use of curare places in the hands of the surgeon an agent with which the desired relaxation may be attained. Recent reports covering thousands of operations (Cole, Frank: Staff Meet. Bul., Hosp. U. of Minn., **15**:359, 1944; and Griffith, Harold: J.A.M.A., **127**:642, 1945) are highly enthusiastic, and it appears that curare may soon be commonplace wherever abdominal and pelvic surgery are practiced. However, it is still not without its attendant dangers and these will be considered.

The technic employed in curarizing surgical cases is briefly as follows: An initial dose of 100 milligrams given



SPERRY GYROCOMPASS
"All over the world the prime offensive weapons of the U. S., ships and airplanes, are guided and steadied on their courses by gyroscopes."

STABILITY

Rapid desiccation under high vacuum by the Lyophile* method insures stability of HYLAND DRIED PLASMA just as surely as the gyroscope stabilizes planes and the gyrocompass accurately steers ships on course. Prothrombin, fibrinogen, complement and proteins . . . all are retained in quality and activity in HYLAND DRIED PLASMA just as they are when the blood is first drawn . . . insuring a restored product that has lost none of its original properties.

Readily available HYLAND DRIED PLASMA, is immediately usable . . . no time lost in pre-tranfusion typing or cross-matching. Administration with the new closure, an exclusive feature of HYLAND DRIED PLASMA, is simpler, quicker and safer.

**Licensed By the Lyophile-Cryochem Corporation*

Hyland Laboratories
LOS ANGELES 27, CALIFORNIA

PIONEER PRODUCERS OF HUMAN BLOOD PRODUCTS

by rapid intravenous injection is usually adequate to achieve complete relaxation in young and robust patients, although the factors of age, weight, depth and rate of respiration are to be considered in calculating the dose. This initial dose should not be given until the stage of the operation when relaxation is of definite advantage (*e.g.* closing peritoneum) because the duration of the curare action is not long (from ten to thirty minutes). This is usually sufficiently long to allow for closure but, if not, small additional doses (from 20 to 40 mg.) may be given.

When given intravenously, the paralytic action of the drug is usually evident within one minute. The most frequently observed sequence of events is first a ptosis or drooping of the eyelids, followed by a loss of facial tone, and limp, relaxed musculature with drooping of the head. According to the latest reports, preoperative medication does not seem to affect the curare action. There have been no postoperative complications attributed to its use.

Curare has been used experimentally in conjunction with all the general anesthetics, but most evidence points to the fact that the curare-cyclopropane combination is the one of choice in most cases. Good relaxation is also achieved by using curare in combination with ethylene or nitrous oxide. There is an apparent synergistic action between ether and curare, and when this combination is employed the dose of curare must be markedly reduced to about one third the amount otherwise employed.

In addition to its use in anesthesia, curare has also been employed in the treatment of laryngospasm, in endotracheal intubation, bronchoscopy and esophagoscopy.

Use in Convulsive Shock. Curarization has given the psychiatrist a highly successful method of controlling convulsions induced by metrazol, insulin or electrical shock as used in the treatment of various mental disorders. The use of curare here has in no way altered the therapeutic effectiveness of convulsion treatment, while the complications which have frequently appeared in the past following convulsive therapy have been greatly minimized.

These complications consist for the most part of fractures of the long bones, compression of vertebrae and damage to soft tissues. None of the measures advocated for prevention of these complications (orthopedic restraint devices, hyperextension of spine) has been as universally successful as has the use of curare. Bennett (J.A.M.A. **114**:322, 1940), following an intensive clinical trial, is convinced that fracture complications in curare-controlled convulsive shock are almost impossible unless there is severe pathologic condition of the bone. Cummins (J. Can. M. A., **47**:326, 1942) reports that the incidence of vertebral compressions with curare was 3.4 per cent as compared to 14.8 per cent without curare.

As used to control shock convulsions, an intravenous dose of 1 milligram per kilo of body weight is most often used, the maximal degree of curarization then being achieved in about two minutes. This is recognized by the fact that the patient is barely able to lift his head or legs. The convulsive agent is then administered and by the time the patient regains consciousness the curare effect has disappeared.

Curare has also been found to be of some benefit in the treatment of spastic and dystonic muscular states. Its brief duration of action has probably limited its success in the treatment of these conditions. It cannot alone effect a cure, of course, but the release of rigidity may allow a muscle not completely paralyzed to begin functioning actively, thus facilitating orthopedic manipulations and muscular training.

Untoward Reactions. The clinical usefulness of curare depends in every case on whether sufficient motor nerve paralysis can be achieved without embarrassing respiration. Although the use of a standardized curare has decreased the dangers involved, there still remains a relatively small margin of safety between the doses causing motor nerve paralysis and paralysis of the diaphragm. Each report on the clinical use of curare, however enthusiastic it may be, invariably ends on a note of caution stating that the drug should never be used except where facilities for administering artificial respiration are available.

Resuscitation by artificial respiration, if instituted promptly, may be expected to carry the patient through the paralysis. Prostigmine is used as a physiologic antidote, and the respiratory paralysis may be removed by use of this drug. One cc. of a 1:2000 sterile solution of prostigmine is the most frequently employed dose.

Curare Substitutes. Because of the low margin of safety, the fact that it is a mixture of compounds and not a single compound (thus precluding a chemical assay) and the difficulty in procuring supplies of standardized material, curare falls short of fulfilling all the desiderata of the ideal neuromuscular blocking agent. Such an ideal agent should abolish all plastic muscle rigidity and athetoid movement, have a large margin of safety, be relatively nontoxic and free from action on the central nervous and cardiovascular systems, have a prolonged effect and be effective upon oral administration.

There are a number of drugs with a curare-like action: quinine compounds, erythroidine hydrochloride, quatenary ammonium bases, snake venoms and various products of muscular metabolism. It is highly possible that somewhere in this galaxy exists an agent that will fulfill the conditions outlined. Some of these have been tried and found lacking, others are under active investigation at the present. Until such an agent is found, the conservative use of standardized curare preparations currently available is to be encouraged.

Japan's Medical Equipment

Japanese military medical equipment is practical and civilian medical practices are relatively modern. Many of the drugs dispensed have been discarded in European and American medical circles, and some preventives examined have been found to be without effect. Extensive use is made of drugs that have to be injected. Field kits contain ampules of a wide variety of sizes and shapes, with no standardization for shipping and packaging.

Much use is made of proprietary (patent) medicines and standard drugs, such as quinine, iodine and aspirin. Antimalarials besides quinine apparently are being used in increasing quantity. Vaccines and serums are comparable to those in use in other armies, although there are indications that some of them are not effective. Vitamin products are used extensively in the form of powders or tablets, as well as in solutions for injections. Even medical kits contain such vitamin tablets.

A great variety of medical instruments is in use. Most of these appear to be only fair in quality, of nickel-plated carbon steel instead of stainless steel. Blood transfusion kits examined are bulky and fragile, usable only with a system of transfusion discarded some years ago by other armies. No evidence of the use of blood plasma has been found.—O.W.I. Report.

"FOR ALL PATIENTS IN NEED OF IRON

it is desirable to use a compound which gives good results with the least discomfort."*

FERGON rarely causes gastric distress even when taken before meals, for its low degree of ionization makes it virtually non-astringent and non-irritating. Ferrous gluconate is utilized with greater efficiency as demonstrated by clinical comparison with other iron compounds.*

Fergon

Ferrous Gluconate Stearns

FOR IRON DEFICIENCY

SUPPLIED as 5% elixir, bottles of 6 fl. oz. and 16 fl. oz.; 2½ grain tablets, bottles of 100; 5 grain tablets, bottles of 100, 500, and 1000.

Frederick Stearns & Company

Division

DETROIT 31, MICHIGAN

NEW YORK • KANSAS CITY • SAN FRANCISCO • WINDSOR, ONTARIO • SYDNEY, AUSTRALIA • AUCKLAND, NEW ZEALAND

FACTS ABOUT FERGON

FERGON is *improved* ferrous gluconate. Prepared by a special Stearns process and stabilized by an excess of reducing agent, it contains no more than 1/7% ferric iron.

NON-IRRITATING because of its low degree of ionization, Fergon is rarely associated with gastric distress. Hence it may be administered before meals, thereby facilitating maximum absorption.

MORE EFFICIENT utilization of iron is demonstrated in clinical studies comparing ferrous gluconate with other iron salts. It is readily soluble throughout the entire pH range of the gastro-intestinal tract.

INDICATED in the treatment and prevention of anemias due to iron deficiency; especially valuable in patients who do not tolerate other forms of iron.

DOSAGE: Average dose for adults is 3 to 6 tablets (5 gr.) or 4 to 8 teaspoonfuls elixir daily; for children, 1 to 4 tablets (2½ gr.) or 1 to 4 teaspoonfuls elixir daily.

FURTHER FACTS FOR YOUR REFERENCE FILE AND CLINICAL SAMPLES WILL BE GLADLY SENT ON REQUEST

*Reznikoff, P. and Goebel, W. F.: J. Clin. Investigation 16:547, 1937.

TRADE MARK FERGON—REG. U. S. PAT. OFF.

CLINICAL BRIEFS

Conducted by E. M. Bluestone, M.D.

More on Refrigeration

The symposium on refrigeration in surgery by Alfred Large, Peter Heinbecker and Jacque Bruneau in the November 1944 issue of the *Annals of Surgery* discusses the benefits and risks of refrigeration as applied to the surgical treatments of gangrenous limbs.

Packing of a gangrenous extremity in ice, combined with the use of a tourniquet, possesses the well-known advantages of anesthesia of the affected part and the elimination of absorption of noxious agents. Relieved of the pain and toxemia associated with infection, a marked improvement in the general condition of the critically ill patient can occur.

As experience in the use of refrigeration accumulates, its limitations are also undergoing further study. This symposium stresses from both a clinical and experimental point of view that the application of a tourniquet with refrigeration proximal to the site of subsequent amputation has the disadvantages of delayed wound healing, a greater risk of infection and a varying degree of actual damage to refrigerated tissues left *in situ*. It is therefore proposed that the benefits of refrigeration can be retained and the dangers eliminated by the application of the tourniquet and refrigerant below the proposed level of amputation.

The clinical use of refrigeration in the surgical treatment of gangrene of the extremities is relatively new. The place of refrigeration in clinical surgery cannot be appraised now. We can expect that as more experience is gained not only will the advantages and disadvantages of refrigeration become more clearly defined as applied to the method itself but also a comparison of refrigeration *versus* other methods in the surgical treatment of gangrenous extremities will be achieved.—Daniel A. Pock, M.D.

Air-Borne Disease

Aerobiology is now considered a pertinent branch of the biological sciences and the phytopathologists have provided tangible evidence for the transmission of pathogenic organisms through the air. Doctor Mitman, in a short review entitled "Aerial Infections," *British Medical Journal*, Jan. 20, 1945, marshals some botanical data to show that plants may be infected by spores or bacteria through the air. If plants, why not animals and man?

The author discusses the weight and the resistance that a particle encounters in the air. To the average biologist a calculation, such as the following, opens up a new physico-biological vista: "In perfectly still air the rate of fall of a staphylococcus 1 micron (1/1000 mm.) in diameter would be about 1 cm. in five minutes." This organism (10 meters above the surface of the earth) moving with the air at a speed of 10 miles per hour would be carried 900 miles before it reached the earth. A droplet of mucus, 50 microns, placed under similar conditions could travel one third mile. In spite of variations in the factors that control this passive flight it is readily conceived that bacteria, viruses and spores may travel great distances.

These organisms have been found in the atmosphere 1 mile above the surface of the earth and from the more recent studies with the aid of high flying planes these organisms have been found in the regions of the strato-

sphere. One must not, however, overlook the climatic factors that govern the flight and viability of the organism. Limiting the air space, as in a sickroom, and eliminating such factors as lack of moisture, radiation and temperature, the pathogenic microorganism may be conceived of as saturating the space.

The author contends that most human respiratory infections take place indoors and holds to the belief that droplet nuclei are responsible for these infections via the air. Further, the author believes that the "contact" idea in infection is not well conceived. In his opinion "contact" should mean "touching" and "aerial infection" should embrace all those modes of transmission in which the path of the infective agent lies through the air.

In discussing the contamination of air in rooms, Doctor Mitman points out that coughing, laughing and talking produce gentle showers of bacteria while the sneeze contributes "veritable intramural storms." In these forceful discharges, estimates of the number of bacteria range from 4600 for a weak sneeze to 100,000 for a vigorous one.

Air conditioning does not ensure any degree of air disinfection. Washing and filtering incoming air do substantially reduce the bacterial count. Circulating air for conditioning purposes increases the bacterial load of the air.

The author further discusses the problem of eliminating intramural infections and believes that the oldest method is by ordinary ventilation through open windows. Ultraviolet irradiation is becoming impressively represented as a means of air sterilization especially in classrooms and children's wards.

Hart, in "Aerobiology" (a symposium in *Science*, 186, 19-12, 1942), investigated the importance of airborne pathogenic bacteria in the operating room. He found that the most rigid, aseptic surgical technic failed to prevent contamination of some of the clean wounds. With ultraviolet irradiation he was able to effect a considerable reduction in the percentage of such infections and reported no deaths from wound sepsis over a period of five and one half years.

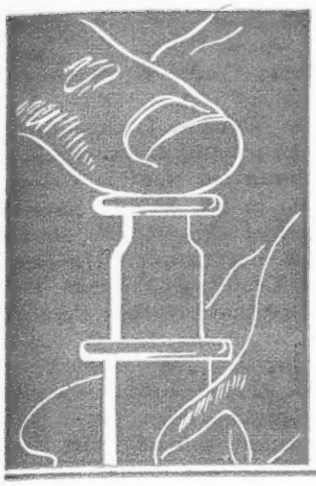
The new knowledge of the control of aerial infection should be incorporated in the postwar rebuilding of hospitals.—MICHAEL LEVINE.

Tuberculosis in Diabetes

A. L. Bonyai and A. V. Cadden, writing on "Diabetes and Tuberculosis" in the *Archives of Internal Medicine* **74** (6): 445-456, 1945, state that while there is a sustained decline in tuberculosis mortality, there are a steady increase in the incidence of diabetes and an increase in pulmonary tuberculosis in diabetics.

Various reasons have been given for the association of pulmonary tuberculosis and diabetes. These views deal with the increased sugar content of the tissues favoring the growth of the organism, local tissue acidosis with imbalance of the electrolyte content and interference with water transport, the lowering of the opsonic index, the production of complement and antibody and of the bacteriostatic capacity of the blood in diabetes, the disordered fat metabolism, the decrease in the defense mechanism and the rôle of vitamin A.

Basing their studies on statistical records of 29 institutions, the authors found the coexistence of these diseases between 0.33 per cent and 0.17 per cent. A decade later they found that the records showed a simultaneous occurrence of diabetes and tuberculosis in 0.31 per cent. In specified sanatoriums studied, there has been a steady increase of diabetes with pulmonary tuberculosis complications from 0.7 per cent to 1.6 per cent. This seems to imply that there are fewer diabetic patients treated in tuberculosis institutions than the estimated number of patients who have diabetes and tuber-



MERCUHYDRIN OPENS THE WAY TO ALL ADVANTAGES OF *intramuscular administration*

1. Eliminates drug impact:

Mercurial diuretics administered intramuscularly are released to the circulation slowly instead of in massive concentration as when given intravenously. Because it is "better tolerated locally" Mercuhydrin may be given intramuscularly, thus avoiding sudden drug impact on conduction centers of the heart.

2. Facilitates stabilization of fluid levels:

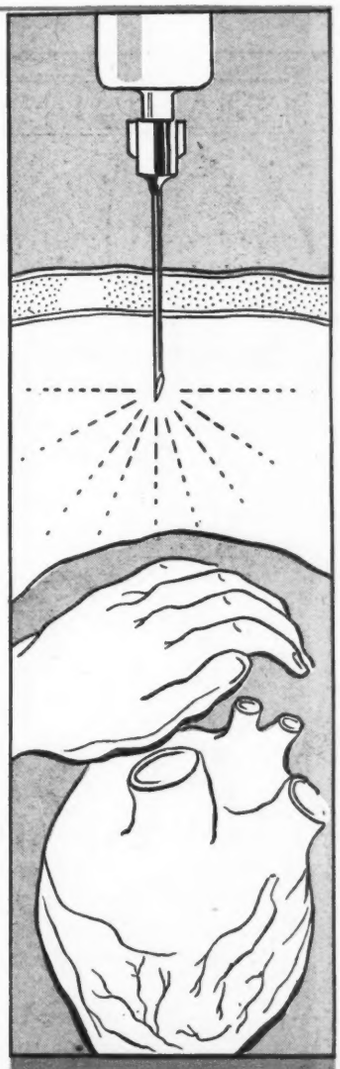
Because it is "better tolerated locally" Mercuhydrin can be given by the intramuscular route as frequently as is necessary to maintain an edema-free condition. This avoids distressing fluctuations in the level of body fluid and in electrolyte balance occasioned by infrequent administration of large doses.

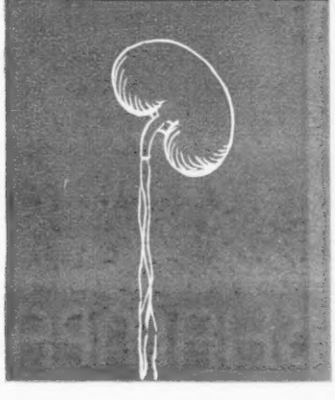
3. Simplifies administration:

Because it can be given intramuscularly without fear of local reaction, Mercuhydrin may be administered by the trained assistant or nurse. This practical advantage makes Mercuhydrin adaptable to recent improved schedules* for maintaining the cardiac patient in greater comfort and with greater efficiency.

Note: While Mercuhydrin possesses definite advantage for intramuscular administration, it also may be given intravenously. By either route it has demonstrated outstanding diuretic efficiency both as to quantity of urine excreted and duraiton of effect.

***Conferences on Therapy: New York State J. of Med. 43:2306, 1943.**





better tolerated locally

Mercuhydrin

MERCURIAL DIURETIC

culosis. The reason for this small number of tuberculous patients with diabetes is ascribed to incomplete diagnostic interpretation.

Experience dictates that the best attitude toward the diabetic is to anticipate the possibility of tuberculosis as a complication and to test the patient annually for the disease bacteriologically, serologically and roentgenologically.

The tuberculous diabetic, the authors believe, responds favorably to such measures as a well-planned diet and adequate amount of insulin. The therapeutic results obtained with the tuberculous diabetic, however, are less favorable than are those recorded for tuberculous patients with moderately advanced and far advanced stages who are nondiabetic—MICHAEL LEVINE.

Supply of Human Blood

The great demand for human blood as a therapeutic agent for war casualties has made the question of supply one of vital importance. The instability of whole blood during long transit periods necessitated the extensive use of the more resistant part of this tissue and so plasma therapy came prominently into general use. The cellular elements separated from the plasma had hitherto elicited no therapeutic interest.

Recently William Thalhimer and E. S. Taylor reported on the utilization of the human red blood cells of the "O" group in the April 28 issue of the *Journal of the American Medical Association*. Their article, "The Transfusion of Centrifuged Human Type O Cells," explains how these red blood cells, after separation from the plasma by centrifugation, were suspended in an isotonic solution of sodium chloride. These suspensions were found beneficial to patients suffering from blood disorders of the anemia type. Red cells in a solution of common table salt were not entirely satisfactory because the cells had a tendency to break down several days after their suspension in this solution.

The authors resorted to other diluents and describe in this report the use of a 10 per cent corn sirup in distilled water which they characterize as an excellent medium for resuspending these red corpuscles. The cells so stored remain in good physical condition for as long as three weeks.

Intravenous injections of large amounts of 10 per cent corn sirup are innocuous. More than 700 transfusions of red blood cells suspended in this medium have been administered without harmful effects.

The authors conclude that when red cells only are indicated, centrifuged blood cells resuspended in 10 per cent corn sirup is as satisfactory as a transfusion of whole blood.

The use of the hitherto discarded red cells in the treatment of anemias is an important additional remedy in blood therapy.—MICHAEL LEVINE.

Replacement of Fluids

In an editorial entitled "Fundamental Replacement Therapy," published in the *U. S. Naval Medical Bulletin* 44 (2): 411-415, 1945, the writer states that replacement therapy had its initial start with the early study of the endocrine system and its hormonal products. Today, replacement of fundamental or essential body fluids due to loss in war and in industrial accidents tends to emphasize the importance of these substances and their life-sustaining properties.

The primary consideration today is not the treatment of the skin denuded by burns but the body of the patient as a whole. His biochemical and physiological conditions must be regulated by replacing with substitutes the body elements lost through the burns. This implies that the surgeon-physiologist and the surgeon-chemist must

complement the work of the surgeon-anatomist and the surgeon-pathologist.

Today the knowledge of the biochemistry of our body fluids makes it imperative that our treatment of the patient be precise and the appraisal of the replacement needs of the patient be carefully considered. The promiscuous administration of any solution, even plasma, must be relegated to the class of defunct procedures. The blood chemistry determinations must be the standard procedure today in the care of the patient.

The frequency with which intravenous injections are given today makes it imperative to determine the condition of the patient's blood. A knowledge of the blood, its capacity to take up oxygen and its coagulability will help to determine the need for transfusion. An accurate estimate of patient's loss of blood during a surgical procedure will more nearly determine the quantity of fluid to be replaced.

Today, the syndrome of hypochloremia is well established but no less so than that of hyperproteinemia. The reestablishment of a proper balance for one should be concurrently carried out for the other. A person who suffers a serious injury or undergoes a major operation sustains a protein depletion notwithstanding the intake of a well-balanced diet. Hydrolyzed protein given by intravenous injections will frequently counteract the lack of protein in the diet with its concomitant effects, such as weakness, lassitude, hypoglycemia and loss of weight.

Today the knowledge of fluid therapy indicates clearly the need for precision as to its indication and its use. Fluid therapy is a fundamental procedure and is recognized as such for surgical as well as burned or scalded patients.—MICHAEL LEVINE.

Use of Frozen Plasma

V. I. Kasanski, writing in *American Review of Soviet Medicine* 2 (3): 207-210, 1945, on "Frozen Plasma: A New Blood Substitute," states that blood plasma in transportation frequently encounters low temperatures and freezes. Under these changes it was believed the plasma protein disintegrated and formed toxic products. The Russian scientists, Davidov, Federov, Vasiliev and their associates, developed procedures for freezing blood plasma without effecting irreversible changes in the protein constituents. This process was accomplished by partially filling ampules or bottles with the plasma and subjecting them to temperatures of —15°C. to —25°C. and, when ready for use, placing the containers in water at from 38° to 40°C. to thaw.

The physicochemical properties of frozen and thawed plasma were studied. Determination of viscosity, turbidity, protein fraction and refractive index was carried out before freezing and after thawing. No irreversible physicochemical changes of the proteins were detected by test or by actual transfusion with human subjects.

The clinical study of the effects of transfusing thawed plasma showed that dosages which varied from 500 cc. to 2000 cc. and given in acute blood loss had no toxic effect on the recipient. Transfusions of thawed plasma for hematological reasons were similar in reaction to fresh plasma. Kasanski concludes that frozen blood plasma like fresh plasma is the best blood substitute. Its biologic value is doubtless lower than that of whole blood.

In view of the common use of powdered plasma in America, the reviewer believes that the frozen product is not a necessity but the result of uncontrolled conditions in the part of the world where low temperatures prevail. That frozen plasma may be used without injury to the patient is apparent from this study.—MICHAEL LEVINE.

This Matter of Meat Supplies

A round-up of reports from dietitians

MANY of the wrong people have been getting our meager meat supplies in the past few months, but the Office of Price Administration has at length been moved by distress appeals from every region and has taken some steps to improve the situation.

While through legitimate channels and sometimes the black market, restaurants have been serving steaks, chops and roasts to those who arrived early and had the price, patients and personnel in many hospitals were getting only luncheon meats, stewing cuts and ground meats and those with worrisome irregularity.

Patients' Diet Inadequate

If no tears flowed over the slim protein offerings to hospital employes, who were in most cases faring better at the hospital than they would have at home, the meat shortage so far as patients were concerned was grave indeed. With other protein and fat supplies curtailed, many patients, particularly in metropolitan hospitals, were not getting the amount of these food elements needed for prompt recovery.

The first break in the growing seriousness of the hospital meat shortage came on June 4 when the O.P.A. put into effect a measure designed to supply hospitals "with as much meat of the same, comparable or reasonably substitute items as they received from suppliers (or their successors) who served them during the March-April 1944 ration allotment period."

This measure was followed on June 6 by an O.P.A. order calling for a 20 per cent reduction in the meat supplies to steak houses and restaurants.

Several days later hospital dietitians were getting official word of the first action and were notifying their suppliers in writing of the following facts:

1. The quantity and type of meat acquired from the supplier during March-April 1944.
2. The institution's meats-fats allotment for meal services during March-April 1944.
3. The institution's meats-fats allotment for meal services for the current allotment period.

This having been done, the supplier must, according to O.P.A. regulations, sell or transfer to the institution the lesser of (1) the quantity of meat requested by the institution for the period or (2) the quantity sold to the institution during the March-April 1944 period adjusted up or down according to changes in the meats-fats allotments for meal services from that period to the current period.

The O.P.A. ruling requires that the supplier must sell to the institution the meat thus authorized. If all of it is not sold or transferred during the period, the supplier may be required to make up the deficiency during the first fifteen days of the next allowance period.

Hospitals must agree to pay O.P.A. ceiling prices for the meat and must surrender the proper red ration stamps to the supplier.

Penalty for suppliers who refuse to sell meat to qualified institutions under the June 4 measure will be prohibition of selling meat elsewhere until the hospital requirements have been met.

By this measure the O.P.A. hopes to restore steaks, roasts and chops to the hospital menu, as well as bacon, ham and other items rarely had in sufficient quantity for some weeks or months.

Nor does the new amendment prevent the sale of meat to hospitals in excess of the prescribed quantity or at prices below O.P.A. ceilings.

Some civilian hospital dietitians, viewing their own hardships in meeting protein requirements, were looking with envy on the Army and Navy hospital menus worked out early in the war which gave patients meat at 20 meals out of 21 each week.

However, the services themselves have had a meat cut, amounting to around 20 per cent, and their various hospitals are observing meatless days or are accommodating their menus in other ways to the reduced supplies. Their dietitians admit that they have a better chance of getting the meat they order than civilian hospitals have had.

In an effort to discover how bad the situation in civilian hospitals has been, editors of The Modern Hospital interviewed a number of dietitians the last week in May and the first in June. The dietitians reported their status at that time briefly as follows:

DOROTHY DE HART, Executive Dietitian, Roosevelt Hospital, New York City.

Practically impossible to get any kind of meat. Mutton off the market completely; no veal. Successful in getting pork for the first time in six weeks. Two items out of five that are ordered come in, chiefly odds and ends. Beef rounds, from which hamburger and such are made, predominate. For weeks unable to get even bones.

Poultry situation is worse than meat situation. Supposed to get 226 pounds of poultry a week under W.F.A.; have received only 69 pounds in two weeks. Must use synthetic base to make chicken broth.

Fish scarce and expensive. Clams and scallops practically off the market. Was quoted $6.50 for 6 pounds of scallops. Black market operators

as active in fish market as in meat.

Eggs getting scarcer. This week [last of May] received first allotment in two weeks. Has been necessary to use frozen eggs. Entire food situation worse than at any time with not much hope of getting better. Dealers really up against it and not getting fair deal. Few complaints from patients who recognize tight situation from experience at home.

Labor situation much improved. At present not an opening in dietary department; files show two applications for cooks.

RACHEL MAYHEW, Nassau Hospital, Mineola, L. I.

Situation here not as bad as in larger hospitals in city. Our dealers take care of us on meat, including various cuts of beef and lamb, and we have not been without chicken as yet. Oleomargarine biggest problem. Adequate supply of Long Island eggs to date. Menus restricted, of course, but situation not acute.

MARY K. BLOETJES, Hospital for Joint Diseases, New York City.

Meat not too serious problem, probably owing to membership in Joint Purchasing Council. Have been getting brisket of beef, sirloin strips, boneless chuck, ham, loins of veal, duck and fowl, smoked tongue and bacon. Use chow mein and spaghetti as meat substitutes.

Eggs scarce. Allowed 10 eggs per patient per week. Sufficient for patient consumption but does not take care of personnel. Fish high; scallops and clams almost prohibitive. Recent purchase of fresh shrimp enabled us to serve shrimp salad, but preparation involved considerable labor.

Sugar threatens to become great problem.

Orthopaedic Hospital, Orange, N. J.

Less difficulty in getting meat and other food commodities in suburban area than in city. Meat available but difficult to get necessary points. Poultry purchased locally. No bacon served since January.

MARY FERRARO, St. Vincent's Hospital, New York City.

Joint purchasing eases problem somewhat. Have had an avalanche of ducks recently; some chicken. Meat situation very acute. Have resorted to smoked tongue and frankfurters but shipment of lamb has been promised.

Egg situation acute. Allotment of ten eggs per patient does not provide for tremendous nursing school. Some aid from small farm operated outside New York. General food condition more acute through high patient census.

Well fixed on sugar because of previous stocks.

MARGARET COWDEN, Michael Reese Hospital, Chicago.

Not only short of meat but short of ration points. Little beef available; veal and lamb, occasionally. Change menus continuously.

No poultry of late. Some kinds of fish but not what wanted. Eggs available so far but not usually of grades desired. No margarine.

ELLA MARIE ECK, University of Chicago Clinics.

In late May meat situation increasingly difficult; until then supply adequate but not of desired types.

In early June no poultry. Desirable kinds of fish quite high. Eggs available but quality uncertain, probably because of errors in vendors not sending what we order because of scarce or inexperienced help.

Margarine in extremely short supply; have gone back to using part butter.

ERMA A. GREIG, Women's and Children's Hospital, Chicago.

Get some beef, then no beef; some lamb, no lamb. Patients have stews twice a week, meat loaf twice a week; few roasts.

From April 1 to June 1 no poultry despite our priority. For fish get halibut and haddock but they are very high. So far have had eggs and margarine.

PLANT PRODUCTS

Offer Flavor and Food Value

IDA BEHAN and LELA BOOHER

General Mills, Inc., Minneapolis

MANY centuries ago primitive man discovered the reproductive capacity of seeds. The detailed story of that momentous discovery is lost in antiquity, but over the succeeding centuries man has increasingly expanded his cultivation of plants, bringing more and more useful species under his supervision, increasing the yields manyfold and developing an astonishing number of new varieties. Edible plant products, new and old, offer almost unlimited possibilities for introducing interesting variety, pleasing flavors, colors and textures and important nutritive values into our diets, with a minimum of hardship on the food budget.

There are in existence at this time around 2500 cultivated species of plants capable of providing food for human consumption and from these have been developed further thousands of varieties. It seems strange that in the midst of this enormous range of edible plants there should be such a dearth of variety, interest and pleasant expectancy associated with our diets. Could it be that man's ingenuity and imagination are dull to the possibilities of providing increased enjoyment of food?

Nutritionists have outlined the basic principles of food selection and these have been translated into simple terms, the seven basic food groups. But it is the dietitian, the homemaker and the restaurant manager who must carry this new knowledge the last mile of the way to the hospital tray, to the family dining table and into the public eating places.

VEGETABLES

Despite much good advice, popular interest in vegetables leaves much to be desired. It has been fairly well established that the lack of interest

in vegetables on the part of the hospital patient and the general public stems from three major causes: (1) monotony in the kinds of vegetables served and in the method of preparation; (2) lack of proper seasoning and destruction of delicate flavors and pleasing textures owing to improper methods of cooking, and (3) failure to serve vegetables temptingly hot and salads crisp and cool.

The endless repetition of potatoes, green peas, string beans, carrots, turnips and spinach cooked in salted water, with a dash of fat added more or less as an afterthought, is not conducive to stimulating interest.

The art of enhancing or accenting the natural flavors in vegetables by the judicious use of carefully selected seasoning agents appears to have been mastered only by a relatively few persons, notably some of the French cooks.

The objective sought in flavor development is to bring out pleasing flavors naturally inherent in the vegetables or in some cases to add a little new flavor that blends smoothly. A little bay leaf, grated onion or onion juice, finely chopped crisp bacon, nippy cheese, lemon juice, chopped celery leaves, chopped parsley or a trace of suitable spice are all accessories that should be a part of the tools in every well-organized kitchen.

Experiment With New Methods

The dietitian, the homemaker and the master chef alike need a small space set aside for experiments on new methods of vegetable cookery and seasoning. Recent examinations and analyses of vegetables cooked for some of our war-plant workers have shown astonishingly high destruction of protective food values which only can be viewed as a most discouraging spectacle of American institutional methods of vegetable preparation.

We are also told that the ascorbic acid values of ordinary American dietaries can be fairly accurately estimated from knowledge of the ingest of citrus fruits and tomatoes. If that is the case, it is confirmation of this sad commentary on American vegetable cookery and our trained dietitians should take the lead in helping to surmount this difficulty.

We are admonished to eat salads —they are good for us, we hear— but one's good intentions wilt before the great, swirling, unmanageable leaves of lettuce or the sections of lettuce head blanketed with overgenerous amounts of heavy salad dressing. A crisp and easily handled vegetable salad, delicately flavored with a little chives, onion, leek, shallot, celery top or capers, offers far greater promise of doing a good nutritional job than do all the admonitions that might be hurled at us. One who masters the art of adding varied piquancy to salads can plan an endless variety of delicious, inexpensive salads that it would be difficult to forego eating.

Demand Dictates Supply

The producers and the retail merchants are too often blamed for the lack of variety among the available vegetables and fruits and for certain poor choices among other foods offered for purchase. But barring certain war-time shortages in particular food items, the law of supply and demand is still operating and it is what the food purchaser is willing to buy that determines the stock of vegetables in the grocers' bins.

Such vegetables as eggplant, Brussels sprouts, lentils, salsify or oysterplant, parsnips, the squashes, cauliflower, kohlrabi, Chinese cabbage, endive, savoy, artichokes, green peppers and the like should continue to add variety and interest to our diets and become more widely used, but whether this will be so is largely dependent upon the quantities of these foods purchasers elect to buy.

Vegetables are nutritionally important. For example, we are dependent on leafy green and yellow-fleshed vegetables for almost 50 per cent of the vitamin A value of our national dietary. Next to milk and cheese, the leafy green vegetables are the most important sources of calcium in the American diet. The calcium in collards, kale, turnip greens, broccoli, savoy and green lettuce is in readily available form; that in spinach, beet tops and Swiss chard is largely unavailable because of the oxalic acid associated with these leaves.

Vegetables also provide bulk and many of them have the capacity to furnish substantial amounts of ascorbic acid if they are properly cooked. In addition to calcium, vegetables supply iron and other valuable minerals, most of which are adequately provided in a reasonably varied diet.

FRUITS

Throughout the year at one season or another there normally appear on our larger markets no less than 20 or 25 kinds of fresh fruits. In addition, there are no fewer than 10 or 15 kinds that are probably in the class of just getting off to a start. During off seasons many of these are available as canned, dried or frozen fruits. There is plenty of opportunity to enjoy fruit.

A few restaurants and institutions have made headway in simplification of their culinary work by passing a bowl of fresh fruits as the finale to lunch or supper and more have found fruit sauces or baked fruits an acceptable end to the meal. Some of our less common and more expensive fruits can be introduced in small portions to provide a new and interesting note to one of the familiar types of salad.

Most supervisors of meal-planning know what a few pieces of chopped figs or dates, a few raisins, a few colorful fresh berries or candied cranberries, a few halved sweet grapes or modest slices of mango or melon can do to add attractiveness and pleasing flavor to a fruit salad. The fresh fruit habit is sometimes slow to become established, but most persons react well to the innovation with a little carefully applied practical education.

One must be careful, as Mark Twain reminds us, not to throw an old habit forcibly out of the upstairs window but rather to coax it downstairs one step at a time. One step at a time is the way good food habits usually become ingrained.

NUTS

Going to the market for nut meats is a matter most of us must consider twice in these days and maybe, on second thought, which usually means a careful eye on the food budget, we do not go at all. But most food budgets will allow us still to take home a few peanuts (which are not nuts at all, we know, but they play the same rôle). By and large the American public has given approval to roasted peanuts but, unfortunately, as we grow up we are usually provided with fewer opportunities to enjoy them.

It is a mistake to restrict the consumption of peanuts to use as peanut butter and odd snacks when they

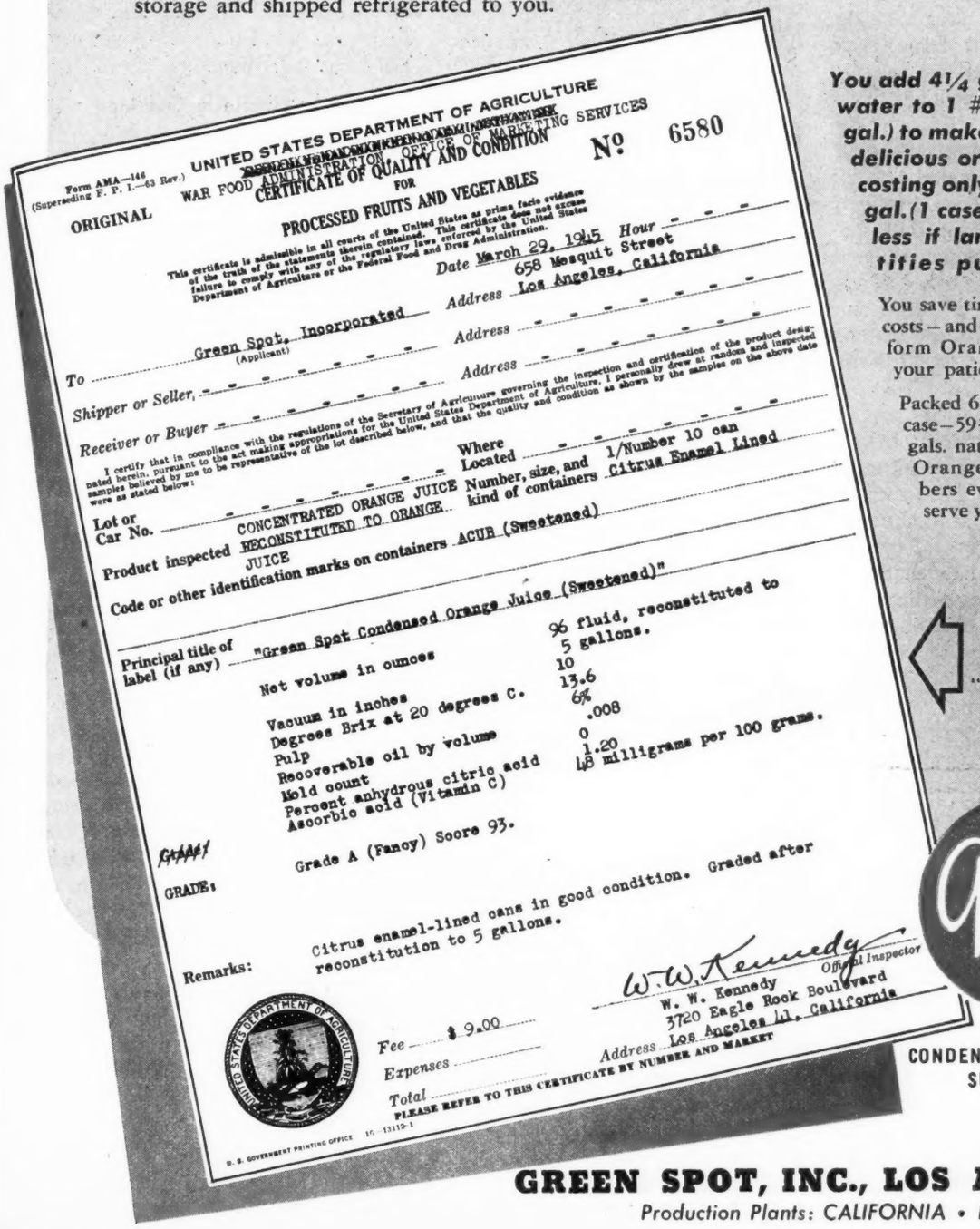
ORANGE JUICE

CONDENSED—ADD WATER AND SERVE

GREEN SPOT vacuum condenses at low temperature the juice of selected tree-ripened oranges within 24 hours of the time the fruit is picked, retaining the maximum amount of natural Vitamin C.

Standardized flavor is obtained by blending the juice of millions of oranges and by adding sugar up to 2%, depending on the natural sweetness of the fruit.

The condensed juice is vacuum packed in citrus enamel-lined tins, immediately placed in cold storage and shipped refrigerated to you.



Form AMA—146 (Superseding F. P. I.—63 Rev.)
UNITED STATES DEPARTMENT OF AGRICULTURE
~~AGRICULTURAL MARKETING ADMINISTRATION~~ OFFICE OF MARKETING SERVICES
WAR FOOD ADMINISTRATION
ORIGINAL
CERTIFICATE OF QUALITY AND CONDITION
FOR
PROCESSED FRUITS AND VEGETABLES
No. 6580

This certificate is admissible in all courts of the United States as prima facie evidence of the truth of the statements therein contained. This certificate does not excuse failure to comply with any of the regulatory laws enforced by the United States Department of Agriculture or the Federal Food and Drug Administration.

Date March 29, 1945 Hour ____

To Green Spot, Incorporated (Applicant) Address 658 Mesquit Street

Shipper or Seller, ____ Address Los Angeles, California

Receiver or Buyer ____ Address ____

I certify that in compliance with the regulations of the Secretary of Agriculture governing the inspection and certification of the product designated herein, pursuant to the act making appropriations for the United States Department of Agriculture, I personally drew at random and inspected samples believed by me to be representative of the lot described below, and that the quality and condition as shown by the samples on the above date were as stated below:

Lot or Car No. ____ Where Located ____

Product inspected CONCENTRATED ORANGE JUICE RECONSTITUTED TO ORANGE JUICE Number, size, and kind of containers 1/Number 10 can Citrus Enamel Lined

Code or other identification marks on containers ACUR (Sweetened)

Principal title of label (if any) "Green Spot Condensed Orange Juice (Sweetened)"

Net volume in ounces	96 fluid, reconstituted to 5 gallons.
Vacuum in inches	10
Degrees Brix at 20 degrees C.	13.6
Pulp	6%
Recoverable oil by volume	.008
Mold count	0
Percent anhydrous citric acid	1.20
Ascorbic acid (Vitamin C)	48 milligrams per 100 grams.

GRADE: ~~GRADE~~ Grade A (Fancy) Score 93.

Remarks: Citrus enamel-lined cans in good condition. Graded after reconstitution to 5 gallons.

W. W. Kennedy Official Inspector
W. W. Kennedy
3720 Eagle Rock Boulevard
Address Los Angeles 41, California

Fee $ 9.00
Expenses ____
Total ____

PLEASE REFER TO THIS CERTIFICATE BY NUMBER AND MARKET

U. S. GOVERNMENT PRINTING OFFICE 16—13113-1

You add 4¼ gals. of ice water to 1 #10 tin (¾ gal.) to make 5 gals. of delicious orange juice costing only $1.07 per gal. (1 case purchase) less if larger quantities purchased.

You save time, labor, cut costs—and serve a uniform Orange Juice to your patients.

Packed 6 #10 tins per case—59# gross = 30 gals. natural strength Orange Juice. Jobbers everywhere to serve you promptly.

Certified by U. S. Dept. of Agriculture "Grade A—Fancy"

Green Spot

CONDENSED ORANGE JUICE
SUGAR ADDED

GREEN SPOT, INC., LOS ANGELES 21

Production Plants: CALIFORNIA • FLORIDA

are capable of rendering much better service. Chopped roasted peanuts lend credit and added interest to salads; provide contrast in texture and flavor in custards and puddings; blend well in a variety of baked goods, and, sprinkled over plain ice cream, add a pleasing flavor and relieve the sameness of that familiar little frozen ball that is so easily served (when it can be found).

SOYBEANS

Some of us, no doubt, have been looking forward with considerable expectancy to the food possibilities of the soybean. The American public has not taken enthusiastically to the use of garden varieties of the soybean for use as a vegetable, despite the fact that soybeans have been widely publicized as carrying rather outstanding nutritive qualities.

Soy flour is also being offered by retail grocers but the purchases for household use have been relatively small. Soy flour has distinctly different characteristics from wheat flour, especially when used in baked goods, but some bakers are blending soy flour and wheat flour in the making of specialty breads and certain sweet goods.

Unfamiliarity with the art of blending flours of different baking characteristics, except on the part of the professional baker, plus the fact that soy flour imparts to the finished product no obvious taste or eye appeal, presents practical difficulties in the way of its ready establishment in our national dietary. The oil of the soybean is, of course, widely used in margarine and vegetable shortenings, and other practical ways and means may yet be found to increase further the utilization of soybean products in human dietaries.

CEREAL GRAINS

Cereal grains were put under cultivation thousands of years before the Christian era and their cultivation has been extended to almost every region of the earth where grains can be grown. In this country the cereal grains provide approximately 30 per cent of the total protein and calories in our national dietary.

The newest developments in the production of flour, bread and breakfast cereals include enrichment and restoration as a means of increasing nutritional values without disturbance of the taste, appearance or general characteristics which consumers are accustomed to associate with these products.

The enrichment of family white flour and bakers' bread and rolls was among the first recommendations made by our national nutrition leaders assembled upon request of the federal government for advice on practical ways and means of improving the nutritional quality of our national diet. For the present, the enrichment of family flour is carried on voluntarily by the milling industry with between 70 and 80 per cent of the total production now being enriched.

Under a war-time food order issued by the War Food Administration, all bakers' white bread and rolls are now required to be enriched in line with the federal standards established for enriched white flour. Meanwhile, in an effort to retain and extend the benefits of enrichment of white flour and bread, state nutrition leaders, health officers and other persons actively interested in promoting the public good are endeavoring to get state laws passed to make the enrichment of white flour and bread a permanent part of the national nutrition program of the future.

Inasmuch as white flour and bread are widely consumed as a part of our daily diets and because these items are relatively inexpensive, the benefits of the enrichment of white flour and bread cannot fail to reach the majority of our population and, most important of all, the benefits are extended to those whose diets are most in need of improvement.

Cereal breakfast foods, breads, rolls, muffins, biscuits, pancakes, waffles and the long list of sweet baked goods are most interesting when provided in variety from day to day and, certainly, there is an almost endless variety that is available or that can be prepared with little effort. Most people enjoy whole-wheat breads occasionally and others enjoy dark breads made with a mixture of white and whole-wheat flours. The baker can usually supply a variety of specialty breads also for those who are interested in adding further enjoyment to eating.

It should be pointed out here that the enriched white bread was not offered or intended as a replacement for other types of bread, nor were the enrichment ingredients selected as a replacement for any previous normal ingredient in bread. The enrichment program was aimed solely at practical and immediate achievement of better national nutrition. Those who prefer whole-wheat breads, dark breads, rye breads or specialty breads will still find them on the market.

Owing to war-time shortages of milk, bakers cannot obtain the same quantities of milk solids for use in bread-making as they could before the outbreak of war. The chief nutritive contributions of milk solids are calcium, protein and riboflavin, and no well-informed nutritionist would consider these nutrients interchangeable with the thiamin, niacin and iron contributions of the enrichment ingredients.

Only Riboflavin Overlaps

Riboflavin used as one of the enrichment ingredients is the only one of the nutritive contributions of milk solids that overlaps significantly with enrichment ingredients, and this is primarily because the riboflavin level for enriched flour was established at a little more than twice the level found in average whole-wheat grain.

If all family white flour or products made with white flour were enriched, cereal products would contribute approximately 40 per cent of the thiamin, 45 per cent of the niacin, 25 per cent of the riboflavin and 45 per cent of the iron recommended as a suitable allowance for the diet of the average American. These figures take into account the average losses involved in ordinary methods of cooking.

In addition to the nutritive contributions inherent in cereal grain products themselves, the cereal breakfast foods and products made with flour act as carriers of other important foods, such as milk on breakfast foods and in baked goods.

The world has need for more people who have the ability to absorb the practical facts about nutrition and to see them carried through to the finish. The enormous variety of pleasantly flavored plant products available throughout most of the year, the importance of their nutritive values and the relatively low cost of these foods should lead us to a rediscovery and enhanced appreciation of plants as the basic source of our food supply.

Menus for August 1945

Grace E. Towell
St. Luke's Hospital
Milwaukee

Elizabeth Hope Tuft
Wesley Memorial Hospital
Chicago

1
Half Orange
Hard Rolls, Jelly
•
Consommé Julienne
Broiled Mackerel
Baked Potatoes
Spinach
Combination Vegetable Salad
Lemon Meringue Pie
•
Cream of Celery Soup
Macaroni Topped With Salted Walnuts
Asparagus
Tomato Slices
Apricots

2
Apple Juice
Poached Eggs, Toast
•
Italian Brown Soup
Roast Lamb, Mustard Pickles
Mashed Potatoes
Stewed Tomatoes
Pea and Celery Salad
Chocolate Pudding
•
Chicken Rice Soup
Creamed Dried Beef With Noodles and Mushrooms
Molded Vegetable Salad
Toast Sticks, Apple Butter
Orange Slices

3
Stewed Prunes
Sweet Rolls, Jelly
•
Vegetable Soup
Baked Trout, Egg Sauce
Au Gratin Potatoes
Beets
Lettuce Salad, Lorenzo Dressing
Apple Betty
•
Cream of Pea Soup
Scrambled Eggs on Toast
Tomato Wedges
Ripe Olives
Watermelon

4
Tomato Juice
French Toast, Sirup
•
Scotch Broth
Swiss Steak
Parsley Potatoes
Green Lima Beans
Spring Salad
Fresh Fruit Cup
•
Cream of Asparagus Soup
Vegetable-Meat Pie
Sweet Mixed Pickles
Carot Curls
Hot Rolls, Marmalade
Grapes

5
Half Grapefruit
Coffee Cake
•
Consommé Royal
Smothered Chicken
Mashed Potatoes
Corn on Cob
Melon Salad
Chocolate Ice Cream
•
Cream of Potato Soup
Open Club Sandwich (sliced tomatoes on toast, bacon, cheese sauce)
Tossed Vegetable Salad
Stuffed Olives
Brownies, Cherries

6
Prune Juice
Soft Cooked Eggs
•
Cream of Pea Soup
Creole Liver
Boiled Potatoes
Peas
Chef Salad
Peach Shortcake
•
Beef Broth
Creamed Chicken
Potato Chips
Molded Fruit Salad
Caramel Cake

7
Stewed Apricots
Poached Eggs
•
Chicken Noodle Soup
Veal Cutlet
Creamed Potatoes
Yellow Squash
Lettuce Salad, Thousand Island Dressing
Plum Upside-Down Cake
•
Cream of Spinach Soup
Deviled Eggs on Lettuce
Escalloped Potatoes
Tomato Wedges
Grapes

8
Orange or Grapefruit Juice
Hard Rolls, Jelly
•
Tomato Rice Soup
Beef Stew With Garden Vegetables
Asparagus
Orange and Cress Salad
Vanilla Ice Cream
•
Cream of Vegetable Soup
Escalloped Corn
Wieners
Carrot, Raisin, Apple Salad
Pears

9
Apple Juice
French Toast, Sirup
•
Alphabet Soup
Spanish Steak
Mashed Potatoes
Julienne Green Beans
Celery Ring Salad
Blueberry Pie
•
Cream of Celery Soup
Sliced Cheese on Spinach Leaves
Baked Stuffed Potatoes
Combination Fruit Salad
Icebox Cookies

10
Half Orange
Soft Cooked Eggs
•
English Beef Soup
Fillet of Sole, Cucumber Sauce
Escalloped Potatoes
Stewed Tomatoes
Romaine Salad
Rhubarb Roll
•
Cream of Tomato Soup
Sandwiches
Salmon Salad
Dill Pickle Slices
Cantaloupe

11
Grapefruit Juice
Scrambled Eggs
•
French Onion Soup
Pot Roast
Oven-Browned Potatoes
Parsley Carrots
Combination Fruit Salad
Burned Sugar Cake
•
Cream of Mushroom Soup
Stuffed Green Peppers
Sliced Tomato, Hard Cooked Egg Salad
Lemon Snow Pudding, Crushed Berries

12
Fresh Plums
Coffee Cake
•
Celery Stock Soup
Baked Ham, Raisin Sauce
Candied Sweet Potatoes
Wax Beans
Fresh Pea and Cherry Salad
Vanilla Ice Ceam
•
Chicken Soup
Cold Cuts
Potato Salad
Ripe Olives
Hot Rolls, Jam
Watermelon

13
Orange or Grapefruit Juice
Omelet
•
Vegetable Soup
Veal Birds
Creamed Potatoes
Baked Italian Squash
Beet Salad
Lattice Peach Cobbler
•
Cream of Asparagus Soup
Cottage Cheese
Vegetable Gelatin Salad
Ribbon Sandwiches
Apricots

14
Cantaloupe
Muffins, Marmalade
•
Italian Brown Soup
Stuffed Flank Steak
Baked Onions
Asparagus
Orange and Plum Salad
Graham Cracker Pie
•
Cream of Pea Soup
Baked Stuffed Tomatoes
Deviled Eggs
Potato Chips
Grapes

15
Prune Juice
Hard Rolls, Jelly
•
Vermicelli Soup
Liver
Mashed Potatoes
Corn on Cob
Tossed Vegetable Salad
Pecan Cherry Pudding
•
Ceam of Corn Soup
Meat Rolls, Spanish Sauce
Spinach Salad
Crabapple Pickle
Pears, Cookies

16
Apple Juice
Poached Eggs
•
Oxtail Soup
Roast Pork
Boiled Potatoes
Broccoli
Spiced Peach Salad
Butterscotch Ice Cream
•
Cream of Celery Soup
Potato Puffs With Sirup
Cold Cuts
Green Bean Salad
Prune Cake

17
Stewed Peaches
Sweet Rolls, Jelly
•
Mushroom Broth
Baked Halibut, Creole Sauce
Baked Potatoes
Harvard Beets
Lettuce, French Dressing
Apple Dumpling
•
Vegetable Soup
Cheese Soufflé, Mushroom and Pea Sauce
Tomato Wedges
Celery Curls
Cherries

18
Tomato Juice
Toast, Jelly
•
Minestrone Soup
Roast Lamb
Lyonnaise Potatoes
Spinach
Salad Bowl
Layer Cake
•
Cream of Spinach Soup
Holiday Spaghetti
Lettuce, Thousand Island Dressing
Carrot Curls
Hot Rolls, Jam
Sliced Peaches

19
Cantaloupe
Coffee Cake
•
Tomato Juice
Roast Duck With Dressing
Mashed Potatoes
Peas
Applesauce Salad, Cinnamon Dressing
Raspberry Ripple Ice Cream
•
Cream of Carrot Soup
Macaroni Salad
Ripe Olives
Blush Pear Salad With Grated Cheese
Chocolate Cake

20
Orange or Grapefruit Juice
Poached Eggs
•
Noodle Soup
Beef Patties
Au Gratin Potatoes
Green Beans
Apricot Salad
Blueberry Pudding
•
Cream of Tomato Soup
Chicken Pie
Sweet Pickles
Spinach Salad
Fruit Gelatin

21
Half Grapefruit
Pancakes, Sirup
•
Barley Broth
Beef-Mushroom Casserole
Hashed Brown Potatoes
Cauliflower
Combination Fruit Salad
Lemon Soufflé
•
Cream of Celery Soup
Tomatoes Stuffed With Cottage Cheese
Hot Asparagus
Cornbread, Jelly
Pears

22
Apple Juice
Soft Cooked Eggs
•
English Beef Soup
Country Style Veal
Boiled Potatoes
Lima Beans
Vegetable Perfection Salad
Chocolate Fudge Cake
•
Vegetable Soup
Creamed Dried Beef on Toast
Stuffed Olives
Waldorf Salad
Gingerbread

23
Stewed Prunes
Cinnamon Toast
•
Pepper Pot Soup
Beef à la Mode
Parsley Potatoes
New Cabbage
Rainbow Melon Salad
Rice Pudding, Fruit Sauce
•
Cream of Potato Soup
Meat Rolls, Spanish Sauce
Shredded Lettuce With Dressing
Celery Hearts
Pears, Crackers

24
Half Orange
Sweet Rolls, Jelly
•
Consommé
Broiled White Fish, Lemon Slices
Escalloped Potatoes
Stewed Tomatoes
Lettuce, Lorenzo Dressing
Apple Pie
•
Cream of Pea Soup
Scrambled Eggs
Stuffed Olives
Hot Rolls, Jelly
Fruit Salad, Honey Dressing
Whipped Gelatin, Custard Sauce

25
Stewed Apricots
Poached Eggs
•
Creole Soup
Country Sausage
Baked Potatoes
Wax Beans
Fresh Pears and Plums
Sunshine Cake
•
Cream of Celery Soup
Macaroni Puff
Sliced Tomatoes
Green Bean Salad
Grapes

26
Fresh Plums
Coffee Cake
•
Firepot Soup
Fried Chicken
Mashed Potatoes
Asparagus
Combination Vegetable Salad
Fresh Peach Sundae
•
Cream of Tomato Soup
Toasted Sandwiches
Cottage Cheese on Spinach Leaves
Hot Peas
Watermelon

27
Orange or Grapefruit Juice
Scrambled Eggs
•
Tomato Okra Soup
Meat and Vegetable Pie
Corn on Cob
Lady Baltimore Cake
•
Vegetable Soup
Stuffed Green Peppers
Sliced Hard Cooked Egg With Dressing
Potato Chips
Baked Apples

28
Prune Juice
Bacon, Cinnamon Toast
•
Split Pea Soup
Roast Lamb
Mashed Potatoes
Spinach
Combination Fruit Salad
Baked Custard
•
Cream of Corn Soup
Spanish Rice
Stuffed Celery
Hot Rolls, Jelly
Lazy Daisy Cake

29
Cantaloupe
Hard Rolls, Jelly
•
Spun Egg Soup
Cube Steak
French Fried Potatoes
Broccoli
Chef's Salad
Apricot Whip
•
Cream of Spinach Soup
Baked Lima Beans
Tomato Wedges
Toast Sticks
Fruit Cocktail
Peanut Butter Cookies

30
Apple Juice
French Toast, Sirup
•
Celery Stock
Meat Loaf, Mushroom Sauce
Creamed Potatoes
Green Beans
Spring Salad
Rhubarb Pie
•
Cream of Potato Soup
Salmon Salad on Toasted Buns
Vegetable Gelatin Salad
Stuffed Olives
Peaches

31 Half Grapefruit, Soft Cooked Eggs • Julienne Soup, Fillet of Pike, Tartare Sauce, Duchess Potatoes, Peas, Pickled Beet Salad, Apple Crisp • Beef Broth With Noodles, Asparagus on Toast, Cheese Sauce, Carrot Curls, Tossed Vegetable Salad, Frozen Pineapple

---

Ready-to-eat or cooked cereals are offered on all breakfast menus.

Just looking won't take it off!

Ry-Krisp Indicated in Diets for Normal Obesity

Ry-Krisp is a "natural" in diets for the normal overweight man or woman because each whole grain double wafer furnishes only about 23 calories yet is an important source of thiamin, phosphorus and iron.

Other Dietary Uses for this Unique Bread

In Allergy Diets, Ry-Krisp solves a big problem for those who are sensitive to wheat, milk or eggs because this crisp-baked unleavened bread is made solely of whole rye, salt and water.

In Common Constipation, due to insufficient bulk, Ry-Krisp is a natural corrective because it contains all the bran and regulating minerals of whole rye; and its high percentage of unavailable carbohydrates further encourages normal elimination.

As a Whole Grain Bread, Ry-Krisp is an all-family, every-meal favorite. A charter member of the Basic-7 foods, this versatile wafer is tops from first course to last. Easy to serve . . . easy to eat. Pamper and please your patients by serving the wafer in the checkerboard package. The wafer with a delightful toasted texture, delicious tangy all-rye flavor. No loss from staleness because it comes packed in wax-wrapped trays. Ry-Krisp stays crisp!

Probably the only 100% whole grain bread available nationally.

FREE! *Allergy Diet Booklet* including lists of allowed and forbidden foods and wheat, milk, egg-free recipes. *Low-Calorie Diet Booklet* giving 1800-calorie diets for men, 1200 for women; menus, recipes. *Chemical analysis cards* for Regular Ralston-Instant Ralston, Shredded Ralston, Ry-Krisp with factual data on their many uses in special diets. Use coupon below.

Ralston Purina Company, Nutrition Dept.
5G Checkerboard Square, St. Louis 2, Mo.

Please send, no cost or obligation, material checked below.

☐ C1008 Allergy Diet Booklet ☐ C75 Low-Calorie Diet Booklet
☐ C873 Chemical Analysis Cards

Name _____

Title or Position _____

Hospital or Organization _____

Street _____

City _____ *Zone* _____ *State* _____

To Facilitate Repair Orders

ROGERS B. JOHNSON

Former Superintendent of Building Maintenance, Harvard University

THE everyday operation of a proper building maintenance and repair organization is not possible without a solid connection between the occupants of the buildings and the staff of the maintenance and repair organization.

A definite system of originating orders, of routing and of executing repair work is necessary to make secure the bridge between the users and the repair department. It must be flexible enough to care for emergencies properly but strong enough to carry all types of overload.

Collaboration Needed

The orders for extensive and periodic repairs, complete renovation, outside painting, new roofs and so on, which are covered by special items in the building budget, will generally originate in the maintenance and repair department but even these must be issued and executed in collaboration with the building occupants and others interested in the building operation.

Miscellaneous repairs and emergency repairs are generally originated, on the other hand, by the patients or by the building operating personnel.

Four groups are involved in the use of a hospital building. The primary group is made up of the tenants—patients, nurses, staff, office workers—for whose comfort and convenience the building is in existence.

Closely associated, from a service standpoint, is the housekeeping group, consisting of those who perform the normal household duties of cleaning, arranging furniture, emptying wastebaskets, unlocking doors and in general seeing that the building is ready for its various functions.

Closely allied to the housekeeping group, and in many small buildings merged with it, is the operating engineering group which is in immediate charge of the heating plant and other mechanical contrivances, such as elevators, ventilating and refrigerating equipment and the like.

The fourth group consists of the building repair and maintenance men.

The housekeeping and the operating groups, as their names imply, are specially trained on the basis of service to the tenant group, one of their definite activities being to serve as a connecting link between the maintenance and repair requirements of the buildings and the maintenance and repair department.

The essential of this liaison relation is the prompt and specific notification to the maintenance and repair department of the necessity of building repairs. A system under which this is done efficiently is of tremendous value to the whole building project. Such a system must be simple and direct and must differentiate between real emergency repairs and the ordinary type.

Everyone in His Own Department

For the type of building maintenance discussed here, the differences between one building service and another as noted should be clear cut. Members of the housekeeping department should confine their activities to housekeeping work and should not, except in cases of emergency, make building repairs. Except in small buildings, where they may be specially trained to take care of heating plants, mechanical operators should handle the mechanical equipment only. They should not make building repairs.

The reasons for both groups being forbidden to make repairs are the same, namely, that the members of these two groups are not trained building mechanics and in the long run repairs made by them are neither permanent nor in keeping with the original quality of the work.

The only functions of these two groups, insofar as building repairs are concerned, are the prompt discovery of any shortcomings in the building and the intelligent reporting of these to the maintenance and repair department.

The work of reporting repair needs can be materially helped by having a suitable standard designation for various localities in a building. This may be done by numbering exterior windows in accordance with a system which will designate the floor as well as the exact location of the window. In other types of buildings, room numbers may suffice or bay numbers may be used. In any event it should be possible for a housekeeper to designate definitely and exactly the location of some specific trouble by the use of such system.

Reports Must Be Definite

The next step is the training of the personnel in the definite designation of the type of repair necessary. For example, a notation that third floor window 43 is out of order is of little value to the maintenance and repair department but a notation that the chain sash line is broken permits the maintenance and repair department to dispatch the proper man to the window with the proper repair parts.

There is also great opportunity for proper training in order writing. The points to cover, besides location and detail, include a notation of the urgency (bearing in mind that to cry "Wolf, wolf" is exceedingly dangerous); a statement of any special difficulty involved; a notation of the times when the job cannot be worked on because the patient will be sleeping or for other reasons.

While each specific repair should have its own individual order, a great deal of cost can be saved if a housekeeper will group all carpenter repair orders for one section of a building together and send them to the

*FOR A LUCKY FEW HOSPITAL SUPERINTENDENTS

Yes, we're acutally installing a few new hospital laundries. In these cases, of course, we've had the orders for a considerable time. Manufacture of laundry equipment is no longer prohibited; but restrictions and shortages and continued production of similar equipment for government use will limit our production for some time to come. In filling our orders, of course, it's "First In — First Out". Why not let us help you get started now? An early start in planning will probably save you many months of waiting.

POUGHKEEPSIE PLANT NO. 1

DON'T DELAY! ASK FOR A HOFFMAN LAUNDRY SURVEY TODAY

U. S. HOFFMAN MACHINERY CORPORATION

107 Fourth Ave., New York 3, N.Y.

COMPLETE LAUNDRY EQUIPMENT SERVICE FOR THE INSTITUTION

maintenance and repair department at the same time. In doing this she must, of course, be sure that such a group does not contain an emergency order.

A further aid which can be given by the housekeeper is the exact specification of the size of such items as broken glass, electric light shades and the like. As a supplement to such size notations by housekeepers, there should be a record in the maintenance and repair office of the exact sizes of different replacement items in each building.

The housekeeper's orders for repairs should be made in triplicate, one copy being retained by her, the other two being sent to the maintenance and repair department. When they are received they should be inspected for completeness of detail, necessity of work, trade or trades involved and should be O.K.'d and turned over to the shops for proper scheduling. In some cases it may be necessary to rewrite the orders but, with proper training of the housekeeping and operating engineering staffs, such rewrites should be few.

When the mechanic goes to the building involved to make the repairs he should always notify the housekeeper that he is in the building so that the latter can make proper notation on her order when the work has been completed and can act as a liaison agent between the tenant and the repair man.

As a supplement to the reporting of minor building repair needs, the maintenance and repair department should institute periodic work inspections of all buildings. These should be made by the representatives of the various trades, the plumbers, electricians, carpenters, and should involve a careful mechanical inspection by each of his particular equipment. Many embryonic troubles will undoubtedly be discovered by such work inspection. It is a "stitch in time that saves nine." For example, one carpenter may find 10 bad sash lines and replace them as a group, whereas if they are discovered and reported by the housekeeper individually as they break it may mean 10 separate trips to repair them. The same is true of leaking washers and slow running drains.

Minor Repairs Reduced

In one large institution the minor repairs reported by the housekeeping staff are sharply reduced for a considerable period after a work inspection.

The large, specially budgeted items of building repair are anticipated by the building maintenance and repair organization and, in general, are the result of tenants' suggestions or building maintenance and repair inspections, although at times they may originate as housekeeping orders.

To summarize the building maintenance and repair problem, it is of the essence that the requirements of the building, in order to make it fulfill its health function, be properly and promptly discovered and that these discoveries be efficiently transmitted to the maintenance and repair organization. That organization, in turn, delegates the jobs to the proper individuals who are the instrumentality for transporting to the point in the building where the trouble exists the proper mechanic with proper tools and repair or replacement parts and with full instructions as to exactly what he is to repair.

LIKE A PRETTY AND KINDLY NURSE FORMICA IS CURATIVE

Formica in colors, patterns and warm "Real-wood" introduces some brightness and gayety, and relaxes the severity of the average hospital room. Like a nurse with personality, it smoothes the way of the patient.

There is the widest variety of color in Formica, so that your decorator can incorporate it into any color scheme. Yet its decorative quality does not detract from sanitation. For Formica is non-porous, non-absorbent material that is amazingly easy to keep clean. It does not stain with coffee, iodine, does not spot with lighted cigarettes. Yet it is not brittle; nor is it cold to the touch.

It is beautiful, clean, durable, combining just the qualities you want for furniture tops.

FORMICA

THE FORMICA INSULATION COMPANY, 4629 SPRING GROVE AVENUE, CINCINNATI 32, O.

HOUSEKEEPING

Conducted by Alta M. La Belle

Having Trash Trouble?

This method makes collection simpler

MILDRED L. BURT
Executive Housekeeper
Mountainside Hospital, Montclair, N. J.

PERHAPS some housekeepers who cannot obtain the equipment illustrated in the article on rubbish disposal in the April issue of The Modern Hospital (page 118) might be interested in the method of collecting wastepaper and similar trash from the hospital floors that is in use at Mountainside Hospital, Montclair, N. J.

Some time before the present shortage of help, we revised our system of rubbish removal from the floors, using a method which has proved to be most satisfactory, particularly at a time when there is lack of help.

Formerly, each porter located on the various hospital floors took his own trash out in the ash cans in which it was collected, using his hand truck to carry the cans out to the waste disposal station, a task which often necessitated several trips a day.

This method was not very satisfactory, since there was considerable noise resulting from the rattling of the cans against the trucks. Then, too, it gave porters a reasonable excuse for leaving their floors whenever they became restless or bored.

Considerable time was consumed in going and coming with the cans, time which was often lengthened by visits with other porters on similar errands. Meanwhile, a porter might be in demand on his floor, yet he could not be found.

At that time the hospital received a donation of several trash cans of the type seen on city streets for the receiving of papers and waste. Enough of these were provided to equip the semiprivate floor and the three private floors.

The trash cans had bags hung on hooks inside them, and one bag could easily be taken out when full and another empty bag substituted. The full bag of trash could be set aside to await picking up later.

We procured an ordinary low truck with four rubber-tired wheels (for the sake of quiet) with a containing frame on three sides and arranged for the head porter to make collections of the bags of rubbish twice a day at regular specified times.

For the other floors on which we did not have this special type of waste can with the bag inside, we decided to make blue denim bags long enough to reach the bottoms of the ash cans we already had in use. The bags are as large around as the cans and long enough to turn over on the outside of the can 2 or 3 inches. This keeps them in place and permits the cover of the can to be put on quietly over the turned-over portion of the bag.

Bags are then taken out of the can twice a day, just previous to the scheduled time for pickup and empty bags are substituted by the porter on that floor. If no porter has materialized on the floor on that day, the head porter can make the change-over easily, himself, on his trip.

If the bag within the can becomes too full before time for the collection, it can simply be taken out and set aside to await the collection truck. Since the bags are made of dark blue denim, they are neat looking when they are set out on the floor, and they can easily be laundered so as to be kept neat and clean for further use.

How Not to Have an Accident

Much helpful material has been published from time to time by the U. S. Department of Labor through the Office of War Information regarding hazards that cause accidents (usually unnecessary) and how to avoid them.

A special bulletin issued to industry on the correct methods of handling and storing materials applies equally to housekeeping and maintenance employes. Here are 10 "do's and don'ts" that will keep your employes from getting hurt.

1. Learn to lift the right way. Keep the body upright; lift with the leg muscles and not with the back. Do not try to lift too much. Get help.
2. Wear hand pads or gloves when handling sharp-edged or rough material.
3. Remove all projecting nails from barrels and crates and from all other places where they might cause accidents.
4. Keep floors clean. Oil or water is especially dangerous on floors near machines or sharp-edged tools and materials.
5. Do not use gasoline or other inflammable substances in a closed room or near an open flame or on a hot surface.
6. All oils, paints and other inflammable or explosive substances should be stored in specially provided safety containers, and only small quantities of such materials (never more than a day's supply) should be taken into the workroom at one time. Containers for inflammable substances should be marked with proper identification and should never be used for any other purpose.
7. Arrange materials carefully and securely. Do not pile or place objects or materials near machines or in such a position that they can fall over or block passageways.
8. When piling materials, do not leave projecting edges or points against which someone may strike.
9. Put all scraps and waste materials into proper receptacles. Keep oily and paint-covered rags in closed metal containers.
10. Keep all aisles and exits clear.

WAX MAKES THE DIFFERENCE

in this new PATENTED maintenance finish!

4 *extra* advantages for your walls with

JOHNSON'S WAX-FORTIFIED INTERIOR FINISH

1. *Rich, lustrous beauty* that only wax-fortification can give.

2. *Decorating cycle lengthened,* because this patented finish lasts longer. Remarkable durability resists stains and mars . . . repels dirt.

3. *Easier cleaning,* when finally necessary, because of the wax. Film retains its rich glow for the life of the finish. Resists caustic cleansers.

4. *High light reflection longer — better light diffusion.* Satin-smooth finish — no harsh glare. Easier on the eyes.

Cut maintenance costs — and have exceptionally fine-appearing walls with Johnson's new Wax-Fortified Interior Finish. This patented finish (which will be available in white and a variety of colors) is impregnated with evenly distributed wax — to give your walls a lustrous, satin-smooth surface with great dirt and wear resistance. It's amazingly easy to clean, too.

Simple to apply

No special preparation is necessary. And, as for application — you'll find it handles easier than ordinary paints because of the lubricating power of the wax. Also it gives broad coverage with great hiding power for marred surfaces—a true economy feature.

No repainting worries

When it finally becomes necessary to repaint, no special cleaning is required. The new coat of Johnson's Wax-Fortified Interior Finish or of regular paint will adhere easily — for the wax in no way interferes.

The versatility and special advantages of Johnson's Wax-Fortified Interior Finish make it uniquely suited to the needs of schools, hospitals, restaurants, food plants, bakeries, dairies, factories, office buildings and department stores. Complete information is yours for the asking — fill out and mail the coupon today!

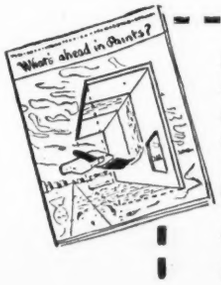
Send for colorful, informative booklet, TODAY

Made by the makers of JOHNSON'S WAX

A NAME *EVERYONE* KNOWS!

S. C. Johnson & Son, Inc., Racine, Wisconsin

Buy and hold MORE War Bonds!



S. C. Johnson & Son, Inc., *Dept. MH-75*
Maintenance Products Dept., Racine, Wisconsin

Gentlemen: I would like to know what "Wax-Fortified" can do for my walls. Please send "What's Ahead in Paints" brochure.

*Name*_____

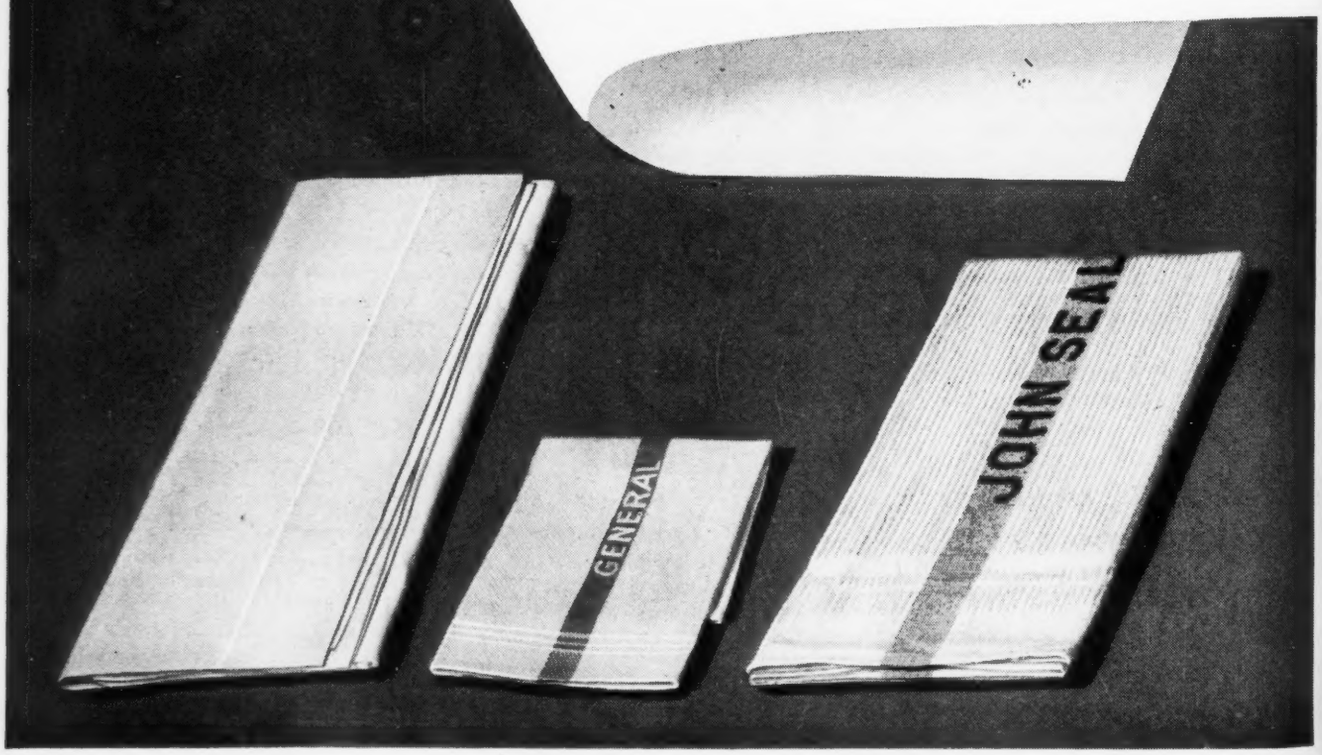
*Address*_____

*Business or institution*_____

SET YOUR CAP

Think of all the people who use or handle the sheets and towels entrusted to your charge. Scores of them, aren't there? If your linens are to last, each must have a share in your campaign to "make 'em wear!"

That's why it's so important . . . especially with new help at work . . . to make sure these few, simple rules are known to every one. Extra care, all down the line, will keep your Cannon towels and sheets in active shape till the day when we can promise all the replacements you are planning!



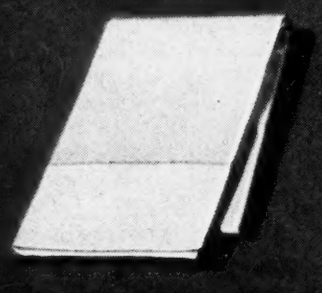
FOR LINEN CARE

CLIP ALONG THIS DOTTED LINE . . .
AND PASS THESE POINTS AROUND

THE RIGHT TOWEL FOR THE PURPOSE. A hand towel at the right place saves unnecessary use of bath towels . . . costs less to launder, too. Don't use towels on sharp instruments. Wise use of cloths and cleansing tissues spares towels many tough jobs.

ROTATE TOWELS AND SHEETS to give 'em all a rest. From laundry to top of pile, from bottom of pile to use . . . that's the share-the-wear program that lengthens towel and sheet service.

FIRST AID to towels and sheets pays dividends. Prompt mending of tears, ravels and breaks adds months of service. And watch out for rough or splintered shelves and hampers. It's easier to fix them than to replace linens. . . . Cannon Mills, Inc., 70 Worth Street, New York City 13.



TRADE MARK MADE IN U.S.A. CANNON

Cannon

TOWELS AND SHEETS

ALL AMERICA'S EMBLEM—THE CANNON LABEL FOR QUALITY, VALUE, WEAR

A.H.A. Trustees Issue Convention Call but Doubt O.D.T. Approval of Meeting

An official call for a meeting of the A.H.A. house of delegates and assembly at the Drake Hotel, Chicago, on November 5 to 7 has been issued by the A.H.A. but probably will not be followed by any meeting this calendar year. The official call was issued to comply with the association's by-laws but the trustees at the June meeting decided to hold no meeting that is in conflict with O.D.T. regulations or lacks specific O.D.T. approval. If present rules regarding traveling are relaxed by November, it may be possible to hold a meeting of the house of delegates.

A grant of $30,000 from the Kellogg Foundation to the A.H.A. educational trust for the work of the joint commission on education was accepted by the trustees. This commission's program was described in the May and June issues of The Modern Hospital.

The trustees referred back to the pension committee its report on social security coverage for hospital employes with the request that the committee explore the possibility of providing old age and unemployment benefits to such employes with the employe paying regular premiums the same as other employes but the hospital paying premiums only for the old age benefits.

It was decided to invite to associate membership in the A.H.A. those architects who are well known in the field and who are unanimously approved by the committee without subjecting them to the detailed procedure of scrutiny that will be applied to others.

The trustees defined the scope of the new council on education to be concerned "with the promotion, establishment and conduct of educational opportunities for those engaged in hospital activities." This statement was subject to the limitations imposed by the existing agreement with the A.C.H.A.

Hospitals were informed by the trustees that it would not be in their best interests to take out membership in the American Association of Nurse Anesthetists and the many other associations of various hospital and allied specialists.

The contract with the U. S. Public Health Service for recruiting cadet nurses was renewed for another year.

The American College of Surgeons was asked to explore the possibility of requiring membership in the A.H.A. as a condition to approval and the Hospital Service Plan Commission was asked to consider whether membership in the A.H.A. could be required of participating hospitals.

The name of the Council on Association Development was changed to the Council on Association Relations. It will continue to have the same functions.

11,000 Amputees Treated in Army Hospitals

Washington, D. C.—Amputation cases in Army hospitals in this country, including cases already discharged, numbered approximately 11,000 up to May 1, according to a statement by Maj. Gen. Norman T. Kirk issued on June 4. Almost 4000 had already been discharged.

The Army does everything possible to help these soldiers make a readjustment. Films are shown to give them a glimpse of the future that is in store for them. One of these, "Swing Into Step," is an encouraging portrayal of how the Army's program cares for a man and trains him for normal life. Another, "The Diary of a Sergeant," shows Sgt. Harold J. Russell of Cambridge, Mass., who lost both arms during this war, doing practically everything he was able to do before. Amputees drive automobiles, ride horseback, use typewriters, eat and dress without help and dance.

The Army has designated seven general hospitals as amputation centers: Bushnell General Hospital, Brigham City, Utah; England General Hospital, Atlantic City, N. J.; Lawson General Hospital, Atlanta, Ga.; McCloskey General Hospital, Temple, Tex.; McGuire General Hospital, Richmond, Va.; Percy Jones General Hospital, Battle Creek, Mich., and Walter Reed Hospital, Washington, D. C. The outstanding specialists in these hospitals maintain close cooperation between the patient and the limb mechanic, physical therapist, occupational therapist and reconditioning officer.

Florida Blue Cross Bill Wins

A vigorous attempt in the closing days of the recent session of the Florida legislature to kill off the law authorizing the Blue Cross and medical plans was finally beaten, according to word from H. A. Cross on June 4. The law had already been passed twice by the house when one of its opponents tried, a few minutes before adjournment, to have it recalled. The legislature also passed a bill for a state hospital survey.

Blue Cross to Counter Wagner Bill With Increased Enrollment

An emphatic protest from the *J.A.M.A.* greeted Senator Wagner's statement that his new version of the Wagner-Murray-Dingell Bill is not socialized medicine. Senator Wagner has not consulted with the A.M.A. or, as far as is known, with any of the members of its representative bodies or councils, the *Journal* declared in its June 2 issue. The A.H.A. trustees at their June meeting took no particular action on the new bill. The A.H.A. is vigorously supporting the Hill-Burton Bill, S. 191, but probably will oppose the Wagner-Murray-Dingell Bill even though it incorporates the Hill-Burton Bill as a section.

No official action by the Hospital Service Plan Commission has been taken on the Wagner bill. In commenting informally on the bill, C. Rufus Rorem said that the Blue Cross answer would probably take the form of increased emphasis on enrollment.

The A.M.A. predicted that action on the bill would be slow as no hearings have yet been scheduled and Congress may adjourn in July or early August.

New York City Group Elects New Officers

Closing another year's business, members of the Greater New York Hospital Association at their eighth annual luncheon held May 25 at the Hotel McAlpin, elected the following officers: president, Dr. Joseph R. Clemmons, director, Roosevelt Hospital; first vice president, Rev. C. O. Pedersen, superintendent, Norwegian Lutheran Deaconess' Hospital; second vice president, Murray Sargent, administrator-in-chief, New York Hospital; secretary, Newman M. Biller, executive director, Home for Aged and Infirm Hebrews of New York, and treasurer, George F. Holmes, superintendent, Memorial Hospital. Mr. Biller as secretary succeeds William B. Seltzer whose appointment as director of Mount Sinai Hospital, Cleveland, has been previously announced in these columns. Mr. Seltzer was honored by the presentation of a testimonial scroll and a wristwatch from his friend and well-wishers.

Hospitals and physicians will work closer together in the future than they have in the past is the prediction of Dr. W. B. Rawls, chairman, Coordinating Council of the Five County Medical Societies of Greater New York. Doctor Rawls sees a definite trend toward group medical practice with the hospital acting as medical center for certain areas. He urged friendly discussion of medical problems and complete agreement on the basic principles involved, also the establishment of standards. He finds organized medicine ready to cooperate.

The need for analyzing existing hospital facilities in planning for the future was emphasized by Commissioner Edwin F. Salmon, chairman, Hospital Council of Greater New York, and chairman of the City Planning Commission. Whether health centers should be identified with hospitals is debatable but a master plan for hospitals should be developed parallel to health centers. He emphasized the need for analyzing the population of a city and also for analyzing and appraising present facilities and developing a plan to use such facilities. Such procedure is a first essential in general city planning.

Dr. Cornelius P. Rhoads, director, Memorial Hospital, and former chief, Medical Service Division, Chemical Warfare Division, U. S. Army, stressed the need for proper expenditure of funds for medical research. The same attention should be given to preventing and curing disease, he insisted, as to perfecting gadgets to make life more comfortable. He believes that the pattern set up during the war period might well be followed in the advancement of public welfare, with similar bodies of lay people to advise with government on the expenditure of funds.

New Mexico Approves Blue Cross Plan; National Office Opens

A new Blue Cross plan in New Mexico has been approved by the trustees of the state hospital association and will be inaugurated as soon as C. Rufus Rorem has an opportunity to check and approve the documents in accordance with the association's request. Ralph George, formerly of the Blue Cross plan of Youngstown, Ohio, will be director of the new organization.

A national enrollment office for national accounts was set up in New York City on July 1 with Frank van Dyk in charge on a half-time basis. Sufficient funds have been pledged for the support of this office by the various plans to enable it to be started on a reasonable basis.

Important changes in the standards for approval of Blue Cross plans have been voted by the Hospital Service Plan Commission and the A.H.A. trustees. They are not to become effective, however, until they are approved by the house of delegates of the A.H.A.

Under these new requirements a plan will lose its approval by next January 1 unless it has at least 1 per cent of the population of its territory enrolled for each year of its existence, with a minimum of 25,000 subscribers after three years. In addition, the present requirements of financial solvency would be strictly enforced.

The A.H.A. trustees also approved the idea of having representatives of several Blue Cross committees sit in with various A.H.A. councils as consultants to assure closer coordination. This is on an experimental basis for a year.

The first general showing of the new Blue Cross movie, "Every Two Seconds," took place in New York City before a group of motion picture editors of newspapers and news services on June 21. This film and a companion film entitled "Blue Cross" were made with grants from the Simmons Company to the Hospital Service Plan Commission.

Red Cross to Expand "Convalescent Swimming" in Military Hospitals

"Convalescent swimming" will be taught to thousands of America's war casualties undergoing therapeutic treatment at military convalescent hospitals in this country, it has been announced by the American Red Cross. In essence the course is "an adaptation of the physical and recreational values of swimming to the reconditioning of physical and mental disability cases." Results already achieved in cases ranging from combat fatigue to permanent disability are sufficiently encouraging, it was said, to warrant extension of the program to military convalescent hospitals throughout the country.

Working in close cooperation with the Army Air Forces' Medical Service, staff specialists of the Red Cross Water Safety Service, responsible for development of the combat swimming course used by the armed forces, perfected the convalescent swimming technics over a period of eighteen months' study and experiment.

Prosthetic Appliances Given

WASHINGTON, D. C. — The Veterans Administration has extended the policy of providing supplementary or emergency limbs to include braces and other types of prosthetic appliances, it was announced here May 31. All veterans who have suffered amputations or will require braces or other prosthetic appliances because of service-connected injuries are included in the program. It is impossible to estimate how many veterans will be affected. The Army has reported 8470 leg amputations and 2530 arm amputations. There are no figures available for the Navy amputations.

Michigan Hospital and Medical Care Plans Increase Benefits

Increased benefits were announced by Michigan Medical Service and Michigan Hospital Service on May 25. The increases were retroactive to April 1 and all groups were expected to be converted by August 1. The hospital benefits carry a slight increase in rates but the medical benefits are increased without added cost to subscribers.

The 1,260,000 subscribers to Michigan Hospital Service and the 790,000 subscribers to Michigan Medical Service automatically became eligible for the new benefits.

Full coverage for hospital care was increased from twenty-one to thirty days with half coverage remaining at 90 days. Each disability now is entitled to the full benefits of the contract instead of having them limited to a certificate year. The waiting period for maternity care was reduced from ten to nine months and was eliminated entirely for other obstetric conditions. Other added benefits are oxygen, penicillin, physical therapy, basal metabolism examinations, all hospital laboratory services and typing of blood donors. Payments for emergency services in nonparticipating hospitals have been increased.

In the medical contract the new benefits now include unlimited surgical operations (formerly with $150 maximum); no waiting period for obstetrics except maternity, and emergency surgical service by a doctor for twenty-four hours after an accident whether the victim is a bed patient or not.

The new hospital premiums are $0.80 per month for ward service and $1 for semiprivate service for individuals; $1.80 and $2.20 for two persons and $2 and $2.40 for families.

New York Hospitals Increase Nurses' Pay

All registered nurses in the department of hospitals of New York City have received an increase of $120 per year, raising the minimum pay to $1800 per year without maintenance; an additional $120 per year will be given to all registered nurses who have been in the department six months or more. Thereafter there will be two increments of $60 each at six month intervals until an annual salary of $2040 is reached.

Nursing supervisors now receiving a minimum of $2040 will also receive these increases until they reach an annual salary of $2400. Proportional increases have also been granted to nurses in the department who are in administrative positions.

All nurses of the department are also entitled to meals while on duty and to free laundry services.

U.H.F. Presents Awards

The United Hospital Fund presented awards to 4006 hospital volunteers, 3517 women and 489 men, in New York City at three meetings, May 23, 24 and 28. Col. Arnold Whitridge, former professor of history at Yale and recently returned from overseas service with the Ninth Army Air Force, was the guest speaker at Carnegie Hall at the meeting for Manhattan, Bronx and Staten Island volunteers, May 23; Rev. Ralph W. Sockman, pastor of Christ Church, New York City, was the speaker at the Brooklyn meeting, May 24, and Prof. Elizabeth M. Lynskey of Hunter College was the speaker at the Queens meeting, May 28.

List Hospital Occupations

Three pamphlets in a series on the outlook for women in occupations in the medical services were published last month by the women's bureau of the U. S. Department of Labor. They cover medical records librarians, practical nurses and hospital attendants and, finally, medical laboratory technicians.

Number Two
of a Series

UNIFORM, DEPENDABLE ABSORPTION

NEXOR Surfacing Gives More Predictable Results

IDEAL STRAND SURFACING

MINIMAL IRRITATION

ADEQUATE TENSILE STRENGTH

PLIABILITY

GAUGE UNIFORMITY

STERILITY

Balanced Quality

A UNIFORM SURFACE free from flaws promotes dependability in catgut suture performance.

To rule out functional weaknesses, Curity Catgut Sutures are polished by machine. This process, *first developed by Curity Suture Laboratories*, is regulated within .0005 inch, to produce the protective surface known as NEXOR.

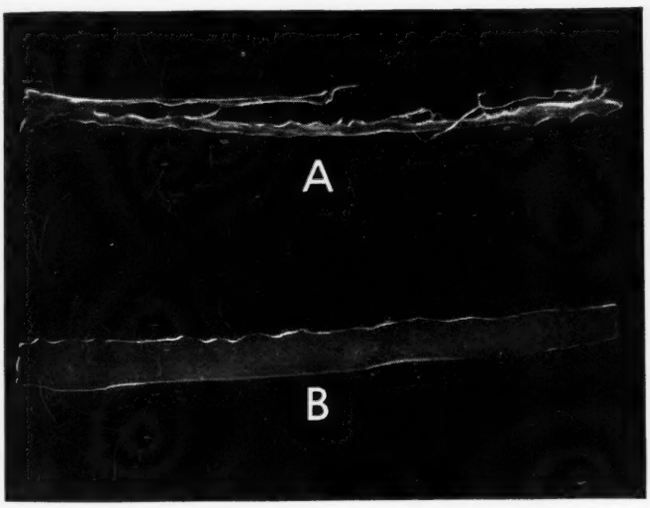
Thus, we remove sharp protruding fibrils and leave the strand free of "whiskers." Yet the degree of smoothness is controlled to retain knot-holding qualities.

Because we do not polish to gauge, we avoid rupturing plies, reducing tensile strength and disturbing absorption rate.

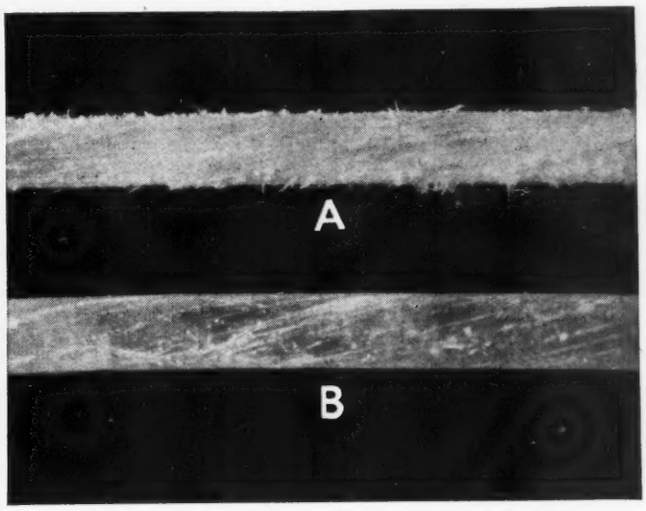
For highly predictable performance in the wound, use Curity NEXOR surfaced catgut—smooth, frayless, yet retaining an optimum coefficient of friction.

★ ★ ★

In addition to indisputable sterility, and to ideal strand surfacing as described above, weighted excellence in the following characteristics is built into Curity Catgut: controlled, dependable absorption rate; minimal irritation; adequate tensile strength; gauge uniformity and pliability.



Untwisted plies recovered from two catgut strands polished to different degrees.
A—ruptured ply from strand polished to gauge; **B**—ply from Curity strand not polished to gauge, surface preserved by NEXOR finishing process.



A—strand surface with "whiskers" which might fray during threading or knot tying; **B**—NEXOR finished Curity strand—smooth, frayless, but with optimum coefficient of friction.

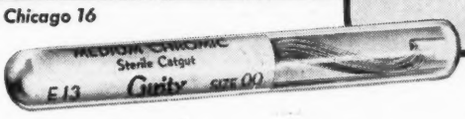
Curity Suture Laboratories

BAUER & BLACK

Division of The Kendall Company, Chicago 16

SUTURE RESEARCH . . . TO ESTABLISH A FINE BALANCE OF NECESSARY CHARACTERISTICS

Curity
REG. U.S. PAT. OFF.
SUTURES



Arkansas Leaders Study Blue Cross Plan

Representatives of the U. S. Department of Agriculture, Arkansas Medical Society, Arkansas Health Department, state planning commission, Arkansas Farm Bureau and other prominent leaders of the state were present at a meeting of the executive committee of the Arkansas Hospital Association in Little Rock on May 29. The committee requested the governor to authorize the state health department to survey hospitals, which was done shortly after the meeting.

Discussion centered around the hospital prepayment plan. Arkansas is now covered by the Pyramid Life Insurance Company of Little Rock because in the beginning two of the larger hospitals would not enter the usual Blue Cross plan. The executive committee studied the growth of coverage under the Pyramid plan compared with that of Blue Cross plans and the extent of benefits to subscribers.

Helen Robinson of the University Hospital, Little Rock, assumed office as president and appointed a nominating committee. Election of other officers is to be held by mail.

The legislative committee has just succeeded in getting a modification of the E.M.I.C. formula adopted as the basis of payment for the care of indigent state wards in voluntary hospitals. The plan provides a minimum of $3 and a maximum of $5 per day.

Des Moines to Have 71 Additional Beds

WASHINGTON, D. C.—To relieve a shortage in the Des Moines, Iowa, war-industry area, 71 more hospital beds will be opened through an additional federal grant of $60,000, F.W.A. announced recently. Living and training quarters for 60 additional U. S. Cadet Nurses will also be provided at the Sisters of Mercy Hospital.

A previous F.W.A. allotment for the two story nurses' home for 50 student nurses amounted to $72,000 with the hospital furnishing $48,000 toward the cost. Stepped-up war activities caused the demand for additional hospital facilities.

Georgetown University Hospital is planning a campaign to obtain $750,000 to help finance its new 400 bed hospital. The appeal will supplement and help guarantee an F.W.A. grant of $1,820,000 provided under the Lanham Act for construction of the new building.

N. Y. Meeting Postponed

Because of travel restrictions of the O.D.T., the annual convention of the Hospital Association of New York State has been postponed from June 11 to 13 to September 10 to 12 in the hope that restrictions will be eased by that time. Since election of officers takes place at the annual meeting, present officers will retain office if no meeting is held. At present, John F. McCormack, Presbyterian Hospital, New York City, is president; Lee B. Mailler, Cornwall Hospital, Cornwall, N. Y., is first vice president; Dr. Morris Hinenburg, Jewish Hospital of Brooklyn, is second vice president, and Moir P. Tanner, Children's Hospital, Buffalo, is treasurer.

Dietetics Course Approved

Albany Hospital, Albany, N. Y., received final approval of its course for student dietitians late last year and will now take a maximum of eight students for the dietetics course, following which students receive diplomas as graduate dietitians and are eligible for membership in the American Dietetic Association. The United States now has 75 courses approved for postgraduate training in dietetics and appointments will be available in schools throughout the country for approximately 960 students in the next year.

Life Insurance Funds Benefit Hospital

An unusual fund-raising effort with many incidental benefits recently brought $156,265 to the Children's Orthopedic Hospital, Seattle. In 1925, a total of 400 life insurance agents in Seattle representing 49 companies approached more than 10,000 prospects to ask them to take out $500 or $1000 policies for the benefit of this hospital. A total of $789,771 of insurance was written during the two week campaign. More than half of this amount was kept in force in spite of the depression, an unusual retention record.

In the intervening 20 years, death claims paid have totaled $77,750; cash values received on policies surrendered during the depression have been $31,618; endowments matured in 1945 were $156,465, and $18,602 has been received by the hospital in dividends. In addition, there are $88,750 still being carried and $25,539 in force on a paid-up basis. During the depression the hospital paid out $32,492 on policies which the owners could not maintain. So the hospital's net total proceeds will be $366,232, all to be part of the permanent endowment fund.

This is believed to be the largest bequest insurance program ever carried on for a hospital. "Life insurance can well undertake such service on a broad scale," according to Holgar J. Johnson, president of the Institute of Life Insurance, New York City. Dwight Mead, who directed the 1925 campaign, said that thousands of institutions in the United States can be endowed by such a program.

Collateral benefits to the hospital included wide public information about the hospital to many people who had not previously heard of it, cash contributions of $16,000, and bequests to the hospital in the wills of some people. Since the original campaign other persons have assigned insurance to the hospital.

Seeks Deferment of Premedics

"At this very moment our government has not been sufficiently intelligent to recognize the danger to the public health that is inherent in an inadequate supply of students for schools of medicine," declared Dr. Morris Fishbein, editor of the *Journal of the American Medical Association,* to the Chicago Medical Society on June 20. Unless Congress or Selective Service takes immediate action to defer premedical students from military service, "we shall see, beginning in 1946, a diminishing medical profession at a time when medicine, not only in the U. S. but in all the world, will be calling hungrily for well-trained men," he stated.

Institute Features Workshops

Group workshop conferences were a new and successful feature of the institute for hospital administrators held at the University of Minnesota during the week of May 21. The registrants were divided into groups and each group was given certain questions that had been asked by the registrants. Each one had to present a reply to his questions. Twenty-six persons were registered from Minnesota, Iowa, Michigan, Indiana, North Dakota, South Dakota and Montana. The program emphasized particularly the public health, nursing and accounting aspects of hospital administration.

New Rate Schedule Adopted

A new patient rate schedule for the inclusive rate plan at Greenwich Hospital, Greenwich, Conn., was adopted on May 1. Simultaneously, the hospital adopted a new salary schedule and the pension program of the National Health and Welfare Retirement Plan, sponsored by Community Chests and Councils, Inc. The new inclusive rate schedule, according to William J. Donnelly, administrator, includes all services but telephone, physicians' and special nurses' fees.

Surveys Under Way in Thirteen States

Thirteen states have statewide hospital surveys under way, or are about to start, as compared with seven states in this category last month. An additional 13 states have enacted the necessary legislation but have not as yet inaugurated their state surveys. Eleven states have taken preliminary action to obtain appointment of survey committees. Four states have completed studies which were started last year but have not conducted detailed surveys of existing hospital facilities.

Thus, 41 of the 48 states have taken some action. At least two of the remaining seven may act to obtain the appointment of a survey committee in the near future.

Surveys were actually being conducted, as of June 10, in Iowa, Massachusetts, Michigan, North Dakota and Wyoming. The eight states ready to start are: Idaho, Kansas, Minnesota, Missouri, Montana, New Hampshire, Wisconsin and Vermont.

The 13 which have enacted legislation but have not actually started work are: Delaware, Florida, Indiana, Maine, New Mexico, North Carolina, Oklahoma, Oregon, Rhode Island, Texas, Virginia, Washington and West Virginia.

States Seek Funds for Care of Alcoholics

New Jersey, Maine and California are requesting appropriations from liquor taxes to help rehabilitate alcoholics and establish institutional facilities for their care. In New Jersey, Alfred Driscoll, alcoholic beverage commissioner, has urged that a fund of $500,000 be established and administered under the joint sponsorship of the Alcoholic Beverage Commission, Department of Health, Department of Institutions and Agencies and the Department of Education.

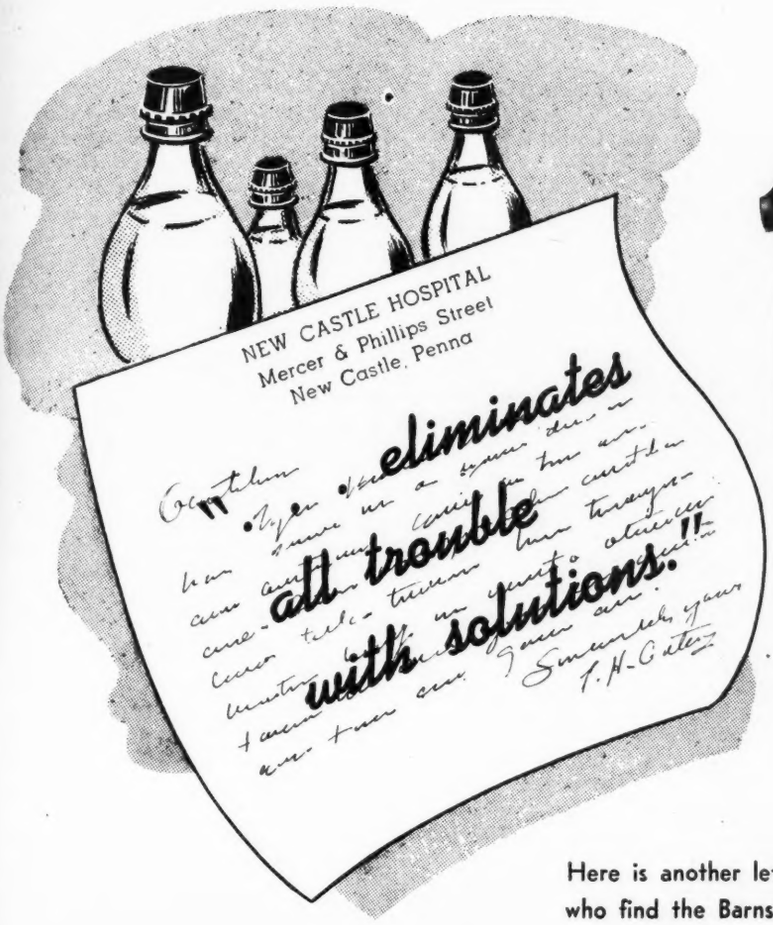
In Maine, state senator Robert B. Dow, chairman of the judiciary committee of the senate, has sponsored a measure which would provide $50,000 per year from Maine's liquor revenue for the treatment of alcoholics.

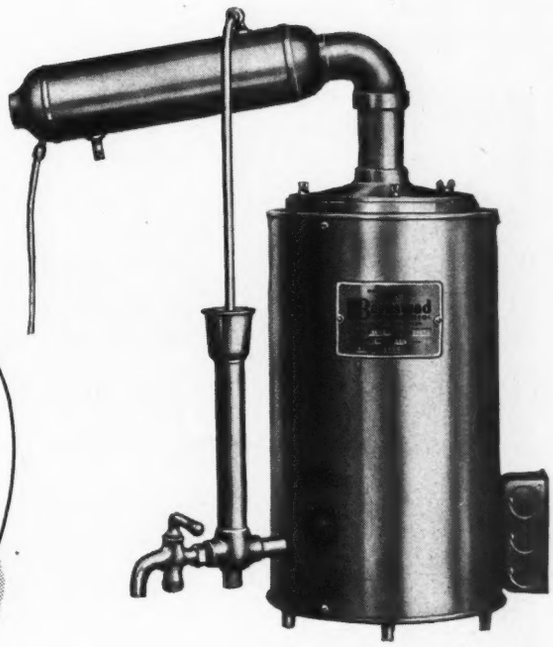
Establishment of a farm to be used exclusively for the rehabilitation of alcoholics was approved by the California Justices and Constables Association. The work will be financed by the liquor tax revenues.

Doctors "Hash It Over"

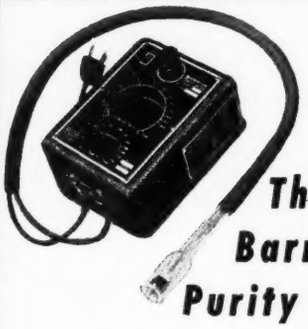
The Jewish Hospital of Brooklyn, N. Y., recently issued its first printed edition of "Hash and Rehash," a compilation of letters received from doctors, formerly connected with the hospital who are now in the service.

BARNSTEAD WATER STILLS
MAINTAIN HIGH HOSPITAL STANDARDS





Here is another letter from one of the hundreds of hospitals who find the Barnstead Water Still to be the ideal answer to their needs. Not only does it supply ample water for routine hospital uses, but the distillate is of such high purity that it can be used with confidence in whole blood and blood plasma work and for intravenous solutions. For a Barnstead Water Still removes pyrogens and toxins as well as chemical, bacteriological and gaseous impurities. It is this additional protection that makes Barnstead Distilled Water the one that "... eliminates all trouble with solutions."



The New Barnstead Purity Meter

Now every hospital can have a simple, convenient, reliable instrument for daily check-up of distilled water purity. Guard against contamination with this handy device which quickly indicates when purity of distilled water meets your standard. Write for bulletin.

TRADE MARK REG U.S PAT OFF

Barnstead
STILL & STERILIZER CO. Inc.

31 LANESVILLE TERRACE
FOREST HILLS, BOSTON 31, MASS.

Army Recommends X-Ray Film Economies

The continuing shortage of x-ray film caused primarily by the stepped-up requirements of the armed forces has prompted governmental departments to institute conservation methods. The W.P.B. has announced the perfection of a fluoroscopic method of inspecting metallic parts that can be used in place of x-rays, and medical x-ray specialists state that hospitals can in some cases substitute fluoroscopic examinations for x-ray pictures.

The office of the surgeon general of the Army Service Forces has issued the following list of conservation methods for medical departments:

1. X-ray examination should not be made when there is no clinical reason to suspect disease or injury in the area under consideration.
2. Follow-up x-rays should be employed only after procedures believed effective have been instituted or after the lapse of an interval of time sufficiently long to cause a significant change.
3. Flat films should be used instead of stereoscopic films when possible.
4. The smallest size film that will serve the purpose should always be used.
5. When a patient is transferred x-ray films should be forwarded promptly as a part of his clinical record.

Music Therapy Course

New York University School of Education is offering a course in music therapy to be given with the assistance of the members of the department of psychiatry July 9 to July 27. Among the topics to be studied will be the physiologic and psychologic effects of music, organization and direction of music activities in institutions and music technics in therapy. Dr. Willem van de Wall, chairman of the committee for study of music in institutions, and Dr. Max Schoen, professor and head of the department of psychology and education, Carnegie Institute of Technology, will be among the instructors.

Rhoads Reveals Plans for Memorial Hospital

A postwar development plan for Memorial Hospital, New York City, has been announced by Dr. Cornelius P. Rhoads, who has returned as director after nearly two years' leave of absence during which he was chief of the medical division of Chemical Warfare Service of the United States Army.

Contemplated for the future are an expansion of the hospital's patient care and laboratory research facilities and an extended clinical research and teaching program in cooperation with the city of New York through its contemplated hospital building for advanced cancer cases. This building will be erected on Memorial Hospital property adjacent to the present structure.

The complete plan will provide 600 beds, the present capacity being 213.

New Jersey Officers

By an election by mail, the New Jersey Hospital Association has elected Charles Lee of East Orange General Hospital, East Orange, N. J., president; Frank Gail of West Jersey Hospital, Camden, N. J., president-elect; George Buck of Mercer Hospital, Trenton, N. J., vice president; Dr. George O'Hanlon of the Medical Center, Jersey City, N. J., executive secretary, and Thomas J. Golden, also of Medical Center, Jersey City, treasurer.

Washington News Letter

First issue of a news letter of the Washington State Hospital Association appeared in May. It is a four page printed bulletin and is edited in cooperation with the Blue Cross plan. The first issue features pictures of the new Renton Hospital.

Renton Hospital Formally Opened

The new 100 bed hospital at Renton, Wash., was formally opened recently. The hospital was built with F.W.A. funds at a cost of $750,000 to serve the residents of South King County and to help relieve the acute shortage of hospital beds in that area.

Renton Hospital is built on one floor with seven wings radiating from a circular hallway surrounding an enclosed courtyard into which patients may be wheeled. Each wing has its direct outside entrance.

The ambulance entrance makes it possible to bring emergency and stretcher cases directly to wing "B" where minor surgery is available for treating patients immediately. Wing "C" contains a central supply room, laboratories, linen room, two major and two minor surgeries, a fracture room and a completely equipped x-ray room.

Wings "D," "E," and "F" are for patients. Each has six private rooms, three double rooms and four four bed wards making a total of 28 beds in each wing. Single rooms are large enough to permit another bed in the event the hospital is overcrowded.

Rockefeller, Menninger Report on Psychiatry

Three quarters of the Rockefeller Foundation's allotment for work in the medical sciences since 1932 has been devoted to psychiatry and related or contributory subjects, according to the foundation's annual report issued during May. The purpose of this program has been "to find, train and encourage first-rate people who were eager to work at the problem of understanding and correcting mental behavior and nervous disorders." More than $400,000 was granted last year and a total of $14,000,000 has been allotted since 1932.

Since it takes four years after graduation to train a doctor in psychiatry and there is a present need for at least 10,000 more psychiatrists, "if all the medical school students graduating from all the medical schools for the next three years were to elect psychiatry as their major interest, we should have enough psychiatrists to meet the present needs by 1951."

This is one of many striking statements in the annual report for 1943-1944 of the Menninger Foundation, which was issued during May.

Early Check-Outs Urged

A "check-out hour" whereby discharged patients are urged to surrender their beds by 2 p.m. daily has been inaugurated in hospitals at Omaha, Neb., that are members of the Omaha Hospital Council. The measure was started recently to speed the departure of dismissed patients and the admission of new ones. The early check-out hour permits the regular domestic force to clean and prepare vacated beds for incoming patients, thus relieving nurses of this task. Reservations for beds are held for incoming patients until 5 p.m., after which accommodations are assigned to the next on the waiting list unless circumstances justify reserving the bed for a longer period.

Nurses Get Pay Increase

An increase of $10 per month in the basic pay rate of nurses at Alexandria Hospital, Alexandria, Va., has been approved by the board of directors. The board further approved payment of $5 per month extra for nurses who put in a full month's duty on the 3 p.m. to 11 p.m. and 11 p.m. to 7 a.m. shifts.

Nurses' Residence Dedicated

Mount Sinai Hospital, Milwaukee, dedicated its new nurses' residence in May. The structure will serve as both a nurses' home and educational center for Mount Sinai Hospital nurses and students participating under the cadet nurse program.

Croft Predicts Strong Advance in Unionism

Organized labor's strength will wane only temporarily after the war and within a few years after V-J Day unions will be stronger and more militant than before, A. C. Croft, president of the National Foremen's Institute, Inc., New York, predicted in a privately circulated memorandum of June 6.

He said that union membership will decline as war employment drops but the reduction will be much less than the 50 per cent estimated by hopeful management observers and the loss is unlikely to total as much as 25 per cent. The decline will be temporary, he said, and when a new production program is in effect unionism will again go on the offensive. He also predicted that the veterans will largely be won over by the unions. He asserted that to minimize losses, unions will become more militant than they have been at any time since their great organizing drives.

Little validity is ascribed by Mr. Croft to the contention that the split in union ranks is sapping its strength. Down at the grass roots, A. F. of L., C.I.O. and independent unions work together, he reported.

Physicians' Group Backs Hill-Burton Bill

Hearty endorsement of the purposes and general provisions of the Hill-Burton hospital construction bill was voiced on June 5 by the Committee of Physicians for the Improvement of Medical Care, Inc., headed by Dr. Channing Frothingham. Several suggestions for changes were made in the committee's statement.

The government should not permit hospital and other facilities that it constructs to be exploited by certain individuals and staff appointments should be made only on the basis of competence, the committee stated. It opposed having the hospitals devoted to luxury services with unlimited doctors' fees.

The committee urged that there be adequate medical staffs for the proposed hospitals, that they function as educational institutions, that they attract and retain superior men and that they provide care for veterans.

Medical Care Plans Step Up Benefits

The United Medical Service, Inc., of New York City announced on May 23 that it would include medical as well as surgical and obstetric costs for patients while in hospitals at an additional cost of 12 cents per month, or a total of 64 cents for an individual and $2.36 for a family.

Group Health Cooperative, Inc., countered on June 1 by offering to provide visiting nurse service for its subscribers at no increase in premiums. This plan covers doctors' bills in any hospitalized illness, as well as doctors' bills for surgical care in the home or doctor's office. It includes obstetric care.

United Medical Service hopes within the next thirty days to announce a trial plan of prepaid protection against medical bills in homes and physicians' offices as well as hospitals. This plan will, in the beginning, be limited to 25,000 people to obtain actuarial experience.

Provident Opens Nurses' Home

Provident Hospital, Chicago, officially opened its two story brick building for nurses recently with dedication ceremonies in which 65 Negro cadet nurses in training at the hospital paraded to the ceremonies and joined with hundreds of Negro and white visitors in inspecting the building.

New Jersey Joins A.H.A.

The New Jersey Hospital Association voted to become an affiliated section of the American Hospital Association and this offer was accepted by the A.H.A. trustees meeting in Chicago in June.

A.C.H.A. Institute to Be Held in Chicago September 17 to 28

An intensive series of lectures on the "Elements of Administration" will highlight the thirteenth Chicago Institute for Hospital Administrators to be held at International House, University of Chicago, September 17 to 28.

The program will emphasize: (1) general principles of organization, (2) professional service to the patient, (3) business management, legal, political and sociological aspects of hospital administration and (4) professional and public educational functions of the hospital. Dr. Malcolm T. MacEachern will serve as director for the institute. Lecturers have been chosen from among the outstanding hospital administrators in the United States as well as recognized authorities in allied fields.

The institute will be open to persons who at the present time are administrators or assistant administrators of hospitals. Registration will be limited to 50 and applications will be considered in the order in which they are received.

Rooms will be provided at International House for registrants at the rate of $1.50 per day. Attractive meals are served in the cafeteria at moderate prices. Registration fee is $20. Application blanks and further information can be obtained by writing to Dean Conley, executive secretary, American College of Hospital Administrators, 18 East Division Street, Chicago 10.

Offer Short Course to Maine Administrators

A short extension course in job analysis and administrative practice designed particularly for small hospital administrators is to be held September 20 to 22 at Colby College, Waterville, Me. Participating as sponsors in the project are Julius S. Bixler, president of Colby College; Dr. Frederick T. Hill, president of the Maine Hospital Association, and Pearl E. Fisher, secretary of the association.

Frank E. Wing, director, New England Medical Center, Boston, will serve as coordinator of a program in which the following will participate as the faculty:

Dr. Joseph C. Doane, medical director, Jewish Hospital, Philadelphia; Abbie E. Dunks, assistant director, New England Medical Center, Boston; Oliver G. Pratt, director, Salem Hospital, Salem, Mass., and Raymond P. Sloan, editor, The MODERN HOSPITAL.

Disabled Civilians Examined During Rehabilitation Week

WASHINGTON, D.C.—Specially arranged clinics for the examination and treatment of disabled men and women civilians were held throughout the country between June 2 and 8, the period designated by President Truman as National Rehabilitation Week, Federal Security Administrator Paul V. McNutt announced recently. The purpose is to locate the physically and mentally handicapped and take the preliminary steps necessary to restore them to employability.

Notice was given that on certain days physicians and surgeons will examine every disabled person who asks for help. If his disability can be removed or reduced, medical care or surgery will be provided. If the applicant cannot afford to pay for such service, the costs will be borne by the state. Hospitalization, up to ninety days, will also be provided if necessary. The work of the medical men will be supplemented by that of vocational experts.

C.-E. A. Winslow Urges Unified Health Program

"The people of the United States need and demand the right to good medical care. They can obtain it for what they are now spending—four billion dollars a year—but only through a unified national health program," Dr. C.-E. A. Winslow, professor of Public Health at Yale Medical School, declares in *Health Care for Americans,* a 32 page pamphlet published in May by the Public Affairs Committee, Inc., of New York.

"If we were to spend half as much again," Doctor Winslow adds, "we could have better medical care than we now dream of."

Basing his conclusions on authoritative medical surveys by such groups as the American Public Health Association, the Health Program Conference and the Committee on the Costs of Medical Care, Doctor Winslow finds that, to provide complete medical care for all the people, a national health program would have to be broad, providing a high quality of service for all who need it, regardless of their ability to pay; it would have to provide preventive and diagnostic, as well as curative, services, and it would have to be administered under conditions satisfactory both to the public and to the professions.

The national health service should be locally administered and supported by social insurance and general taxation, according to the pamphlet, if it is to meet the health needs of all income levels in our population.

"Of course Otis makes small freight elevators, too."

For a great many years, small freight elevators made up the greatest part of Otis business. Today, they still constitute a large percentage of Otis sales.

Small or large, for two stories or twenty, with Otis freight elevators you are assured of dependable and economical performance.

Your Otis representative is ready now to consider your requirements and to recommend the elevator equipment best suited to your needs. For the finest in vertical transportation tomorrow, call your Otis representative TODAY.

Otis ELEVATOR COMPANY
OFFICES IN ALL PRINCIPAL CITIES

OFFICIAL ORDERS
May 15 to June 15

Aluminum Cooking Utensils.—Limitation Order 1-30-e controlling production of these utensils was revoked on May 26.

Blankets.—All deliveries of wool blankets and blanketing made from yarns produced between June 17 and Sept. 1, 1945, have been frozen to rated orders. Under the direction (Direction 4 to M-73), exceptions were made for the most part affecting the manufacture of such items for hospitals and similar institutional users. Such exceptions to the order will generally be granted only to persons who, since Jan. 1, 1944, have sold blankets or blanketing directly to or for the use of such users. It is expected that the direction will permit enough blankets to meet minimum essential needs. Hospitals are advised to place orders as soon as possible.

Canned Milk.—O.P.A. on June 10 took steps to cut off further supplies of canned milk from establishments using it in large quantities so that it would continue to be available for infants, invalids and other consumers to whom it is essential. Red points cannot be used by institutional and industrial users to purchase canned milk except on special permission. Hospitals are not restricted.

Electric Cooking Equipment.—Order L-65 was revoked on June 16, thus permitting the production of commercial electric cooking and food preparation equipment insofar as manufacturers are able to obtain materials. W.P.B. will grant priorities assistance for limited production of 20 types of commercial electric cooking and food preparation equipment for civilian use during the third quarter.

Enameled Ware.—Order L-30-b was revoked on May 26, thus permitting the manufacture of enameled ware as soon as materials, facilities and manpower are available. Restrictions on types and sizes of enameled ware had been removed from the order on November 14.

Fuel Oil.—Increasing military requirements and transportation difficulties in the Pacific Northwest make necessary the continuance of present restrictions on civilian fuel oil in that area, the Petroleum Administrator for War announced on June 1.

Plumbing Fixtures.—Restrictions on the use of metal in the manufacture of plumbing fixtures were removed from Order L-42 on June 2. Manufacture and distribution are still controlled by other W.P.B. orders, however.

Rationing.—A lowering or leveling off of bases in keeping with consumer point issuances has been made in amendments to G.R.O. 5, effective June 13. An official of O.P.A. said these changes would not affect hospitals materially because these institutions can get supplemental allotments. Point issuance to home consumers is not, at this time, comparable to the maximum per person allowances granted to institutional users, O.P.A. pointed out in announcing the changes. The amendments revise the maximum per person allowance downward in keeping with consumer point issuances.

Refrigerators.—Resumption of production of domestic mechanical refrigerators for the third quarter of 1945 was announced June 4. All the refrigerators made in the third quarter will be added to the frozen stockpile and will be released by W.P.B. only to meet military, hospital and other highly essential requirements. Some 265,000 are slated for manufacture. Hospitals that have had some trouble getting such refrigerators may have a better opportunity now of getting them. They should still file applications on Form WPB-882.

Screening.—Order L-305 was amended on June 1 to assure that the limited amount of metal insect screening available for civilian use would go to hospitals and other essential civilian users.

Sheeting.—To offset heavy demands for Class A sheeting on high rated orders, solid blue denim is being substituted for this material for the production of women's work clothing, W.P.B. announced June 14. Denim is in more plentiful supply than Class A sheeting.

Sugar.—The tight world situation on sugar means that civilian allocations will be much lower in the third quarter of this year than the actual distribution of sugar in the corresponding quarter of last year.

Vacuum Cleaners.—Order 1-18-b limiting the production of domestic vacuum cleaners was revoked on June 11.

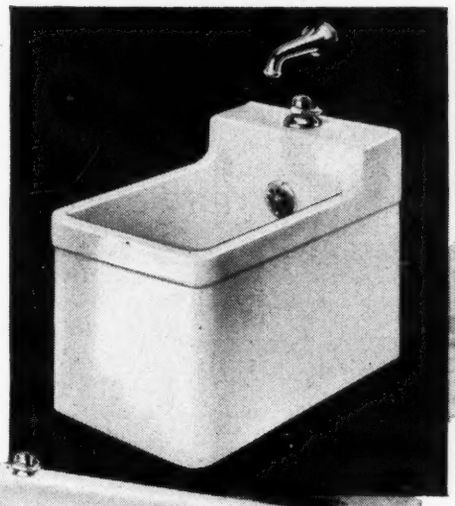
Uniforms.—The production period during which nurses' uniforms may be manufactured has been extended until the end of September, W.P.B. announced June 7. The additional time was authorized because fabric shortages made it impossible for manufacturers to fulfill contracts within the limits of the old period which was to have terminated at the end of this month. Authorization for the extension is contained in Supplement X1, Schedule A to M-328B. Some uniform manufacturers, however, contend that the priorities are not good unless W.P.B. gives the mills a directive to set aside the required amount of material for the third quarter, as practically all mills are sold out through the third quarter on materials which the uniform manufacturers are permitted to use.

Washing Machines.—An amendment to L-6 on June 7 permits the unlimited production of domestic washing machines. It also provides a method for granting priorities assistance to manufacturers for the production of a limited number of domestic washing machines within approved W.P.B. programs. So long as a manufacturer complies with all applicable orders and regulations, he may distribute his domestic washing machines as he sees fit unless he is directed otherwise in writing by W.P.B.

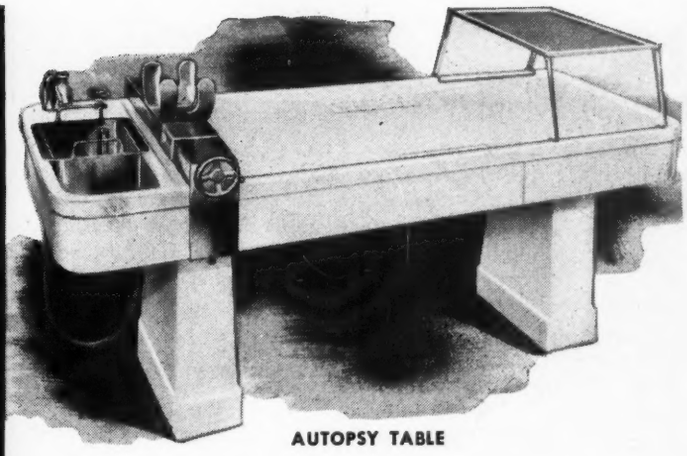
Zippers.—Slide fasteners, hooks and eyes, snaps, buckles and other closure items that have been made of steel or aluminum during the war can again be manufactured from copper base alloy under a metal exchange program announced by W.P.B. on June 11.

Goldwater Index Available

A 15 page index of the published writings of the late Dr. S. S. Goldwater, noted hospital administrator who died Oct. 22, 1942, is now available at the Bacon Library of the A.H.A. in Chicago.



FOOT SOAK BATH



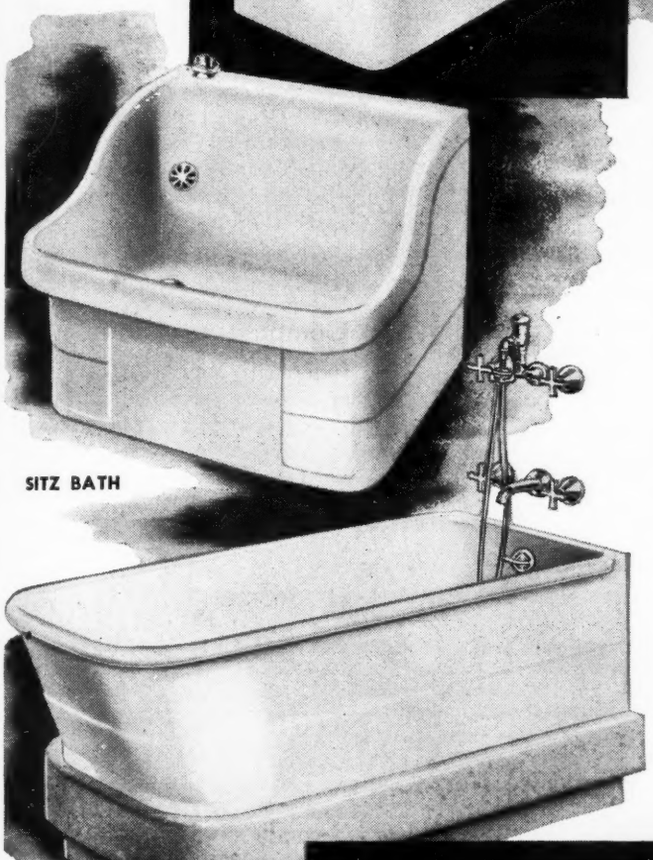
AUTOPSY TABLE

Quality Fixtures of Crane Duraclay

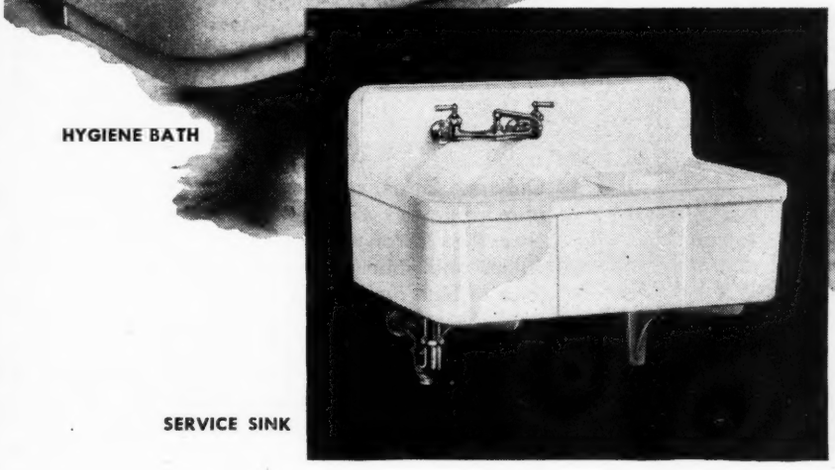
To meet the highly specialized needs of hospital plumbing, Crane Co. developed a new material: Duraclay. This is an all-ceramic product impervious to ordinary acids—a product that is highly resistant to thermal shock and will not craze. Being pure white and having a smooth, hard surface, it is easy to keep clean and is an aid to hospital asepsis.

Hospital fixtures of Duraclay were introduced in 1939 and since that time have won enthusiastic acceptance in hospitals from coast to coast.

For the replacement of old fixtures—for remodeling your present hospital or for installation in the new hospital you are planning—you will find a wide range of quality fixtures of Duraclay in the Crane line.

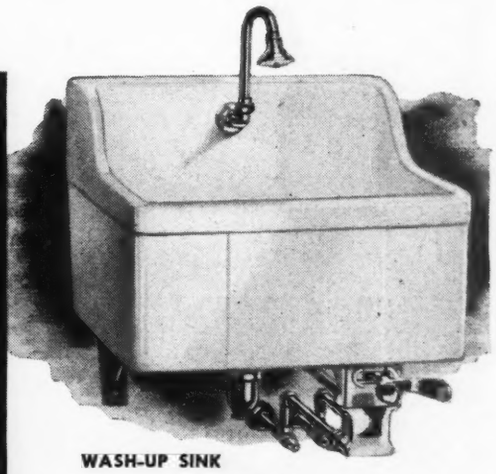


SITZ BATH



HYGIENE BATH

SERVICE SINK



WASH-UP SINK

90 YEARS OF PROGRESS 1855 1945

CRANE

CRANE CO., GENERAL OFFICES:
836 S. MICHIGAN AVE., CHICAGO 5

PLUMBING • HEATING • PUMPS
VALVES • FITTINGS • PIPE

NATION-WIDE SERVICE THROUGH BRANCHES, WHOLESALERS, PLUMBING AND HEATING CONTRACTORS

Building Plans Are Announced by Post-Graduate Hospital

New York Post-Graduate Medical School and Hospital announced a $15,000,000 building program at a dinner in May marking its seventieth anniversary. Dr. William B. Talbot, superintendent, set an immediate goal of $5,000,000 for a 12 story center that will house the hospital's clinics, laboratories and teaching facilities.

Funds for the construction of the other three units will be begun after the present goal is achieved. Unit 2 will be a 20 story structure devoted primarily to semiprivate and private pavilions, adding 200 beds to the hospital's present 400 bed capacity. Unit 3 will consist of 16 stories and will contain medical school offices and library, department of dermatology, intern quarters and laboratories.

Unit 4 will replace the Roosa Building which at present consists of teaching wards, administrative offices of the hospital, school and department of nursing.

Housekeeping Course Offered

Among summer courses to be offered this year at Cornell University will be a course on housekeeping to be held from July 30 to August 4. Tuition for the course is $12.

Denver Nursing Workshop

A workshop in nursing education was started at the University of Denver on June 25 to run to July 13 in cooperation with the Colorado State League of Nursing Education and the U.S.P.H.S. Edna S. Newman, director of Cook County School of Nursing, Chicago, and Carmelita Calderwood, Iowa State Teachers College, were named to serve as specialists in nursing education.

New Welfare Island Hospital

Construction of a new 750 bed hospital costing $6,000,000 was voted by the New York City board of estimate on May 24. The new Metropolitan Hospital will replace the existing Metropolitan Hospital on Welfare Island. A nursing school and residence will also be constructed when materials are available.

"Texas Hospitals" Published

The first issue of *Texas Hospitals,* a new monthly magazine established by the Texas Hospital Association, appeared in June. It is a 24 page journal with approximately the same page size as the national hospital magazines. Madelyne Sturdavant, who since February 1 has been the full-time executive secretary of the association, has been appointed as editor.

Adopt Policy of Selective Admissions

Abbott Hospital, Minneapolis, has adopted a selective admission policy that will probably soon be adopted by most of the other hospitals in the city. Not more than six selective cases are accepted each week day and, with eight or nine discharges per day, room is available for emergencies. As there are usually 17 or 18 discharges over the week end, elective cases are then accepted in the order of their filing. No more than two patients of any one physician are put on the operative schedule for any one day.

Under this plan, elective surgery is now being scheduled about five weeks in advance and the occupancy of the hospital is stabilized to the point that in two months there have been more than two vacant beds at census period on only two occasions, according to Victor Anderson, administrator.

Raise Compensation Rates

The Industrial Commission of Colorado has adopted increased rates for hospital care up to $4 per day for ward treatment and $5.50 per day for private rooms when necessary plus the costs of extras, it was announced by the state hospital association on May 31.

"hospitals—of all places—appreciate the constant cleanliness of DIXIE CUPS"

Wherever maintaining health standards is a "must", single-use Dixie Cups render valiant service. Utterly clean, they check the spread of mouth-to-mouth infections among staff and patients. Always ready, they eliminate washing, drying, sorting, sterilizing. Figure for yourself how far this can stretch *your* curtailed man-power.

DIXIE CUPS, VORTEX CUPS AND PAC-KUP CONTAINERS ARE MADE AT EASTON, PA., CHICAGO, ILL., DARLINGTON, S. C., TORONTO, CANADA

ABOUT PEOPLE

(*Continued From Page* 73)

Miscellaneous

Rev. John J. Bingham, director of the division of health care of New York Catholic Charities, has been named papal chamberlain with the title of very reverend monsignor. Monsignor Bingham is a former president of the Hospital Association of New York State, a trustee of the United Hospital Fund and a member of the Greater New York Hospital Association.

Cmdr. Mary D. Towse, U. S. Navy Nurse Corps, has retired from active duty after twenty-seven years of continuous service with the Navy. In 1917 she was appointed a reserve nurse for the Red Cross at the Naval Hospital in San Diego and since then has served with the Navy throughout the United States and at sea aboard the *U.S.S. Mercy*. At the time of her retirement, Commander Towse was on the staff at the Office of the Central U. S. Naval Medical Department Activities with headquarters in Chicago.

Mary Beard, retired director of the Red Cross nursing service, was awarded an honorary Ll.D degree at the sixty-seventh commencement exercises at Smith college recently. Miss Beard was the only nurse among the five outstanding women who were awarded honorary degrees by the college.

Pearl McIver, chief of the Office of Public Health Nursing, Bureau of States Service, U.S.P.H.S., and chairman of the Council of Federal Nursing Services, is the new chairman of the National Nursing Planning Committee of the National Nursing Council for War Service. She replaces **Marion W. Sheahan** who has resigned but will remain a member of the executive committee.

Sarah Blanding, dean of the school of home economics of Cornell University, has been appointed a member of the Commission on Hospital Care. Miss Blanding is also director of the human nutrition division, New York State Emergency Food Commission, associate director of the office of war nutrition services of New York State, member of the joint Army and Navy commission on welfare and recreation and a member of the American Council on Education.

C. Horace Hamilton, Ph.D., director of the department of rural sociology of the University of North Carolina on leave, joined the staff of the Commission on Hospital Care on June 15 as director of sociological research. He will assist the commission to make recommendations to meet the needs of areas of scattered population and low income.

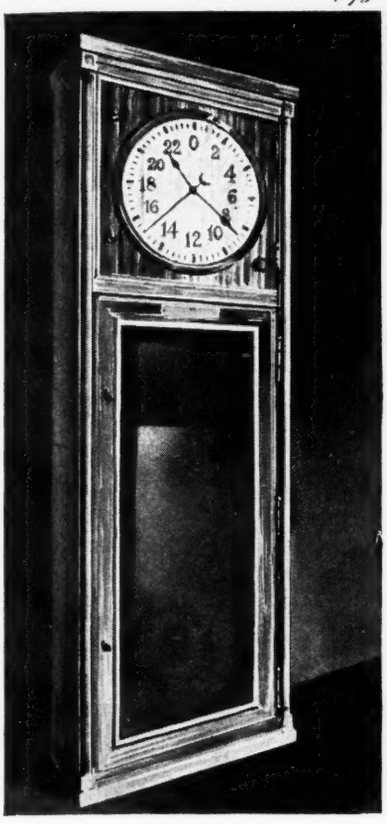
Doctor Hamilton served as an economist in rural life at Texas Agricultural and Mechanical college and as a senior social scientist in the division of farm population and rural welfare of the U. S. Department of Agriculture.

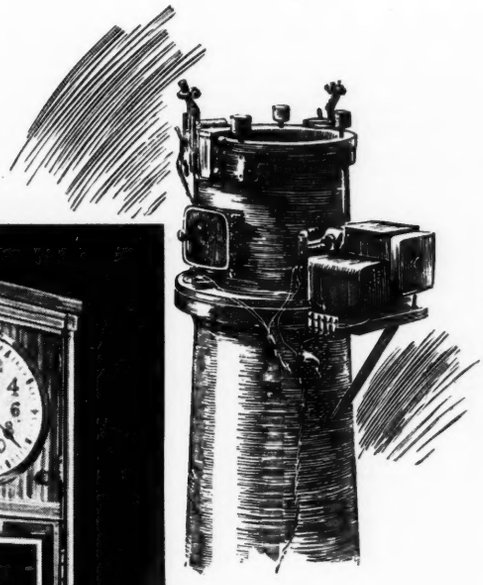
Deaths

Lake Johnson, administrator of Good Samaritan Hospital, Lexington, Ky., died June 17. Miss Johnson, who had been head of Good Samaritan Hospital since 1926, was a charter fellow of the American College of Hospital Administrators and served as vice president of the American Hospital Association in 1933. She was also president of the Southern Methodist Association in 1933 and of the Kentucky Hospital Association in 1934.

Dr. Maurice H. Rees, dean and superintendent of the University of Colorado School of Medicine and Hospitals, Colorado General and Colorado Psychopathic Hospitals, Denver, died of a heart attack in June. Doctor Rees was a fellow of the American College of Hospital Administrators and a member of the A.H.A., the Colorado Hospital Association and the American Medical Association.

William W. Davison, 51, assistant superintendent and chief engineer of Passavant Memorial Hospital, Chicago, died on June 24.





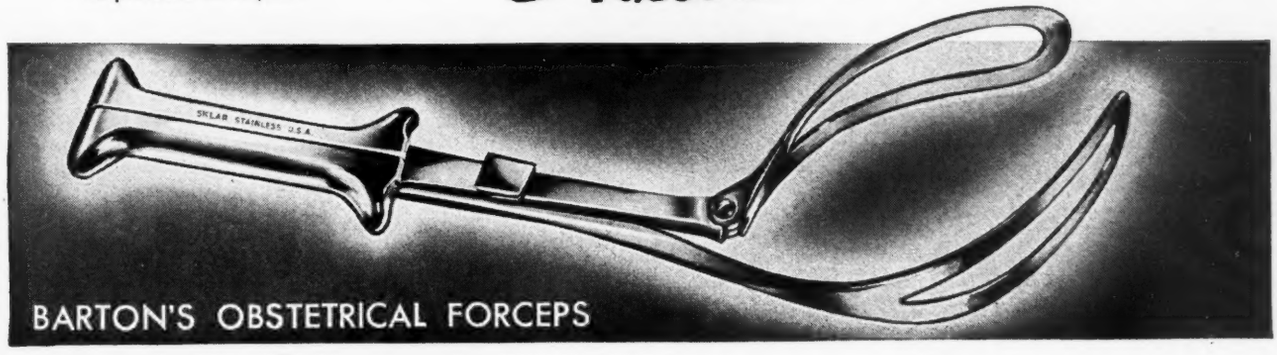
PHOTOGRAPHIC ZENITH TUBE . . . U.S. NAVAL OBSERVATORY. This precision photographic device records graphically both clock ticks and signals from the photographic telescope in the time control vault of the Naval Observatory . . . determining the nation's clock time within one-thousandth of a second.

Perfection IN ITS FIELD . . .

PHOTOGRAPHIC ZENITH TUBE . . . U.S. NAVAL OBSERVATORY . . . which helps make the Navy's time service 100 years ahead of any chronometrical system the world has ever known . . . is regarded by experts as the most perfect time control mechanism yet invented. And as the Navy is serving the nation in the vital matter of time control, so, too, SKLAR is serving the surgeon by providing him with professional products of such technical perfection that he can depend upon them with absolute confidence. And that's because SKLAR has always pioneered in research . . . kept abreast of each new surgical development. And this traditional policy . . . plus rigid insistence upon quality both in materials and workmanship . . . has made the J. SKLAR MANUFACTURING COMPANY the leader in a highly specialized industry. ***All SKLAR products are sold only through accredited surgical supply distributors.***

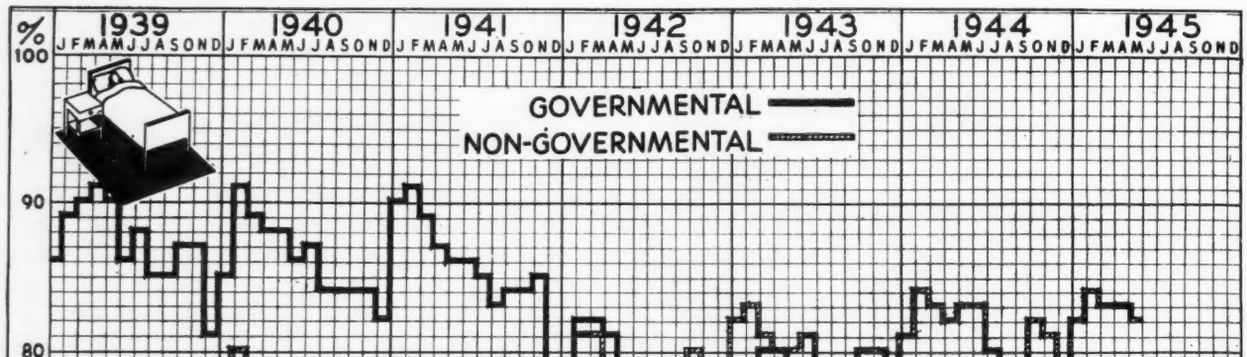
A catalog of Sklar Stainless Steel instruments will be provided on request.

Sklar LONG ISLAND CITY, N. Y.



BARTON'S OBSTETRICAL FORCEPS

Construction $40,000,000 Over Last Year



Occupancy in May dropped off one point in the nongovernmental general hospitals but stayed the same in the governmental general institutions. The spread between the two, however, was 12 points. This is in marked contrast to May 1939 when the governmental hospital occupancy was 17 points higher than in voluntary institutions.

Fifty-one hospital building projects were reported from May 14 to June 11, which together with late reports, were to cost $30,000,000. The total reported construction for this calendar year is $86,200,000 as compared with $46,800,000 for the same period of last year. There were 15 new hospitals of which 11 gave costs of $19,000,000; there were 31 additions and 25 gave costs of $6,800,000; two alterations will cost $112,000, and three nurses' homes, $457,000.

What's New for Hospitals

JULY 1945 SUPPLEMENT TO THE MODERN HOSPITAL AND THE HOSPITAL PURCHASING FILE

Metallic Sutures

Surgaloy is the name of the new metallic sutures which have been developed by Davis & Geck. The result of six years of research and clinical observation, the new sutures are designed to fulfill all requirements of the surgical profession for sutures of this type. Studies of numerous metals and their qualities and suitability for this purpose resulted in the development of an alloy of chromium, nickel, steel and other ductile metals to produce exceptional strength even in fine sizes, flexibility, freedom from kinking, non-corrosiveness and inertness, non-magnetism and electro-passiveness in tissue fluids.

Encased in hermetically sealed, heat-sterilized glass tubes, the new sutures have swaged-on atraumatic needles especially designed for the procedures in which metallic sutures are used. The range of suture sizes and needle designs available offers all needed suture-needle combinations. **(Key No. 2646)**

Davis & Geck, Inc., Dept. MH, 57 Willoughby St., Brooklyn 1, N. Y.

Skin Graft Knife

An inexpensive but effective knife for the free hand cutting of skin grafts has been developed by Dr. G. V. Webster and is available through Edward Weck and Company.

Consisting of an inexpensive, rigid handle with a removable, readily replaceable, single edge blade 2¼ inches long, the knife is designed to simplify the cutting of Thiersch or thick-split grafts by the free hand technic. **(Key No. 2647)**

Edward Weck & Co., Inc., Dept. MH, 135 Johnson St., Brooklyn 1, N. Y.

Synthetic Latex Operating Pads

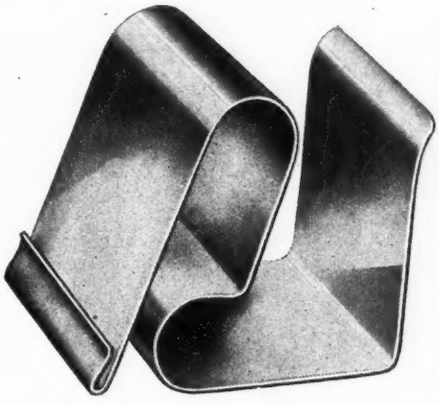
Operating pads, ambulance stretcher pads and flat sheet stock of synthetic latex foam suitable for use in padding casts, pressure bandaging and treatment of leg ulcers are now available for hospitals. Known as U. S. Koylon, this product has been tested for skin toxicity and found harmless.

Flat sheet stock in 30 by 45 inch size is available in four grades from extra soft to firm and in thicknesses from ¼ inch to 1½ inch. The operating and ambulance stretcher pads are available in various sizes and thicknesses, either uncovered or covered with a special vinyl resin coated cloth. **(Key No. 2691)**

United States Rubber Co., Dept. MH, 1230 Sixth Ave., New York 20

Diet Card and Napkin Holder

A new chrome plated diet card holder of nontarnishing metal so designed that it also holds the patient's napkin is an attractive as well as utilitarian addition



to the diet tray. The unit can be placed on the tray or if the tray is crowded, it can be clamped to the rim, thus saving space. **(Key No. 2737)**

Meinecke & Co., Inc., Dept. MH, 225 Varick St., New York 14

Sparkproof Plastic Flooring

Rockote Sparkproof Plastic Flooring is especially designed for use in hospital operating rooms. It consists of Rockote Plastic Primer which is laid over the cement underlayment, Rockote Sparkproof Plastic Underlayment and Rockote Sparkproof Plastic Finish. Plastic is used to eliminate danger from impact sparks and the flooring is grounded by a system of copper ground wires soldered to small brass plates to eliminate static sparks. The new flooring can be quickly installed without disrupting activities of the hospital. **(Key No. 2509)**

Federal Flooring Corp., Dept. MH, 82 W. Dedham St., Boston 18, Mass.

Explosion-Proof Motor

An explosion-proof motor for use in electrical devices used in an atmosphere containing combustible vapors, such as the opertaing room, has been announced by General Electric. The new motor has been tested and approved by the Underwriters' Laboratories. **(Key No. 2688)**

General Electric Co., Dept. MH, Schenectady, 5, N. Y.

Tomac Sanitary Napkins

American Hospital Supply Corporation has announced Tomac Hospital Sanitary Napkins as an addition to its line. Made of a special nitrating sulphite fluff of high absorbency and softness, the napkins have a safety backing of a moisture-repellent paper and have tapered and compressed ends.

Three types are available to fill all hospital needs; the Tomac DeLuxe with extra absorbent cotton over the top and sides, covered with fine mesh gauze with long tabs for nurses and other personnel, the Tomac Special with wide mesh and short tabs for bed patients and the Tomac Standard with medium tabs and wide mesh gauze for all hospital departments. **(Key No. 2735)**

American Hospital Supply Corp., Dept. MH, Merchandise Mart, Chicago 54

Spreader Type Stoker

A new spreader type stoker has been developed which prevents spillage of fine coal. It has a nonclogging and dust-tight coal feeder and a combination mechanical-pneumatic coal distributing system which distributes either lump or fine coal to all parts of the grate area. Water cooling or water jacketing is unnecessary since all exposed parts of the stoker are air cooled. All parts are easily accessible for inspection and maintenance and the coal feeder can be adjusted for various operating conditions and for the size of the furnace.

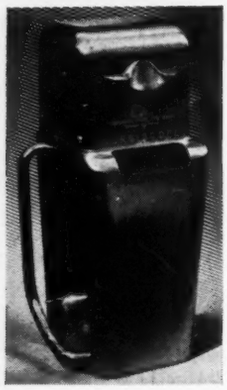
The stokers are available in four standard sizes and can be installed singly or as multiple units to meet the requirements of boilers ranging from 75 h.p. upward. **(Key No. 2679)**

Johnston & Jennings Co., Dept. MH, 877 Addison Rd., Cleveland 14, Ohio

Address manufacturers for further information and prices—or use Readers' Service blank on page 256

Colored Surgical Photography

The surgeon can take color pictures during an operation with the Adel Color Camera and Surgiscope without fear of



infection of the operating area. The Surgiscope, made of light weight aluminum and stainless steel, is made to be autoclaved. The camera is placed within the sterilized Surgiscope and when the surgeon wishes to take a color photograph, he lifts the Surgiscope by the two handles, places the balancing plate against his forehead and merely presses a button near the bottom of the left handle. The field is viewed through a Pyrex window and the Surgiscope can be held close to the operating field. A flash bulb picture can be taken with this simple device in less than 15 seconds. Eight consecutive photographs can be taken without reloading.

The mechanisms of the camera work automatically and the built-in flash bulb is mechanically timed within the camera. Batteries, also, are built-in. Various inexpensive diopter lenses for close photography in eye, ear, nose and throat work are also available. **(Key No. 2683)**

Adel Precision Products Corp., Dept. MH, Burbank, Calif.

Portable Infrared Drying Lamps

The recently developed portable models of infrared equipment used for baking, drying and dehydrating should prove of value in the hospital workshop for quick drying of paint and other finishes on hospital furniture and equipment. There are four sizes in these new models which provide radiation ranging from 275 to 2000 square inches.

The reflector assemblies are attached to the upright support and permit radiation in any direction. The units are equipped with heavy duty casters and are designed to eliminate the possibility of tipping. **(Key No. 2742)**

Fostoria Pressed Steel Corp., Dept. MH, Fostoria, Ohio

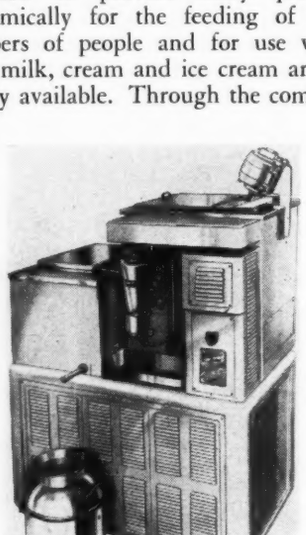
Gastro-Intestinal Sutures

Bauer & Black has announced the addition of Multi-Filament Zytor Gastro-Intestinal Sutures to its already comprehensive line. These new nonabsorbable specialty sutures include gauge sizes #5-0 through #0 attached to a straight gastro-intestinal needle (1-1) and the same range of gauge sizes attached to a small half circle gastro-intestinal needle (1-4). **(Key No. 2733)**

Bauer & Black, Dept. MH, 2500 S. Dearborn St., Chicago 16

Staromatic Dairy

The Staromatic Dairy is a machine designed to provide dairy products economically for the feeding of large numbers of people and for use where fresh milk, cream and ice cream are not readily available. Through the combina-



tion of butter fat, skim milk powder and water, this machine produces milk or cream as needed and in any desired quantity.

The constituent parts of the finished products can be kept indefinitely and formulas for combining the elements of milk, cream or ice cream are provided with the machine. Ingredients are placed in a mixing tank, the machine switched on and when the run is finished, the thermostatically controlled dairy stops automatically. No technician is needed to operate the machine. The finished product is homogenized, nourishing and has the fresh flavor of the original. **(Key No. 2644)**

Star Metal Mfg. Co., Dept. MH, Trenton Ave. & Ann St., Philadelphia 34, Pa.

Ironing Table

A new strong, rigid, lightweight ironing table which folds into minimum size for storage has been developed by Lyon Metal Products. It is suitable for use in nurses' homes, interns' quarters and other places in the hospital where an easily set up ironing table is needed. A positive lock keeps the table rigid when in use and the legs out of the way when not in use. It is easily and quickly opened or closed. **(Key No. 2695)**

Lyon Metal Products, Inc., Dept. MH, Aurora, Ill.

Fire Resistant Paint

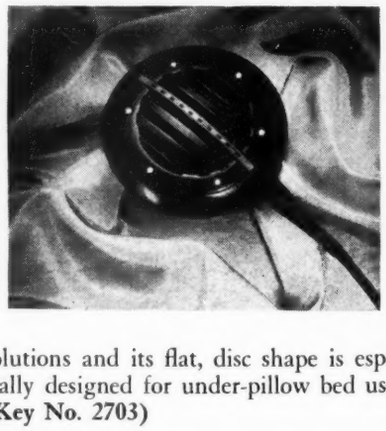
A paint which protects wood and other materials against fire hazard is being offered under the name Fi-Repel. Endorsed by the Underwriters' Laboratories, the product can be applied with a brush or spray gun to any surface to be protected. It is shipped as a concentrated paste and one gallon of the concentrate, when diluted, covers as much as 185 square feet with two coats. The product comes only in bone-white but tints can be added. It is available in 5 gallon and 55 gallon containers. **(Key No. 2687)**

General Detroit Corp., Dept. MH, 2270 E. Jefferson Ave., Detroit 7, Mich.

Individual Radio Speaker

The Hushatone radio speaker for individual use of hospital patients so that those around them will not be disturbed by the program has been improved and streamlined. A miniature, molded plastic speaker with satin chrome trim, the unit is lightweight, durable and has tone quality comparable to large speakers. Sufficient volume for individual listening is produced by very small power consumption.

The unit is hermetically sealed so that it can be dipped into disinfecting



solutions and its flat, disc shape is especially designed for under-pillow bed use. **(Key No. 2703)**

Brush Development Co., Dept. MH, 2373 Perkins Ave., Cleveland 14, Ohio

Address manufacturers for further information and prices—or use Readers' Service blank on page 256

Sun Lamp Bulb

A self-contained sun lamp bulb has been developed by Westinghouse which can be screwed into any regular light socket operating on standard alternating current electricity. For more convenient use, however, a simple, adjustable, portable holder is recommended.

This new lamp emits both invisible ultraviolet radiations and infrared rays. **(Key No. 2680)**

Westinghouse Lamp Div., Westinghouse Electric Corp., Dept. MH, Bloomfield, N. J.

"Tom Thumb" Tray

A small tray which should prove of value in the serving of medicines, nourishments, fresh water and other between meal items, and should also find a place in the nurses' home, has recently made its appearance. Known as the "Tom Thumb Tray," it is designed for carrying in one hand, which in itself is an advantage. A formed opening through which the thumb passes to provide perfect balance increases the ease of handling when loaded with glasses or other items. The tray has a semi-oval or artist palette shape and is made of molded plastic. It is light, easily cleaned, attractive in appearance and handy to use. **(Key No. 2648)**

Associated Merchandisers, Dept. MH, 931 Rives-Strong Bldg., Los Angeles 15, Calif.

Surgeons' Detergent

A soapless cleansing and antiseptic solution for preoperative scrubups, which is at the same time soothing and softening to the skin, has recently been developed. Known as Surgeons' Detergent (Crowe), the product is designed to cleanse thoroughly without the addition of saponified fatty acids, alcohol or other organic solvent, oils or acids. A synthetic product, the detergent also contains phenylmercuric borate 1:2500 as an antiseptic.

In addition to surgical scrubup, the product is designed for cleansing wounds, cleansing and deodorizing tubes and other surgical equipment, for general hand washing, especially among nurses and doctors to keep the hands soft and smooth in spite of frequent washing, and for similar uses in the hospital. **(Key No. 2660)**

Crowe Chemical Co., Dept. MH, Tulsa, Okla.

PHARMACEUTICALS

Sedative-Antispasmodic

Syntronal is a sedative-antispasmodic with a threefold effect in disorders associated with smooth muscle spasm and nervous tension. It inhibits the parasympathetic terminations in smooth muscle, has a direct relaxing effect on spastically contracted smooth muscle fibers and relieves nervous tension and apprehension. It is available in sugar-coated tablets in bottles of 30 and 100. **(Key No. 2706)**

Hoffmann-La Roche, Inc., Dept. MH, Nutley, N. J.

Salicresin Cream

A water soluble cream base ointment, Salicresin Cream exhibits fungicidal, germicidal, anhidrotic and heratolytic properties. The water soluble base mixes well with perspiration and serous exudates. The cream is designed for treatment of fungus infections of the skin, particularly where there is fissuring or maceration with serous exudate and where there is secondary bacterial infection. It is supplied in 2 ounce jars. **(Key No. 2585)**

Upjohn Co., Dept. MH, Kalamazoo 99, Mich.

Calcium Levulinate

Calcium Levulinate is a clear solution providing calcium in a form readily utilized by the body. A combination of calcium and levulinic acid, this product is designed for use in tetany, in allergies, in intestinal tuberculosis and other conditions where calcium is indicated. It is generally injected intravenously but may also be injected intramuscularly or subcutaneously. The product is supplied in 10 cc. ampules in boxes of 6 and 25. **(Key No. 2658)**

George A. Breon & Co., Dept. MH, Kansas City 10, Mo.

Libejex

Libejex is a new product designed for parenteral therapy which contains liver and five components of vitamin B complex. Procain hydrochloride 0.5 per cent has been added to eliminate any pain on injection of therapeutic doses. The product is supplied in 10 cc. ampules. **(Key No. 2659)**

National Drug Co., Dept. MH, 4663 Stenton Ave., Philadelphia 44, Pa.

RECENT CATALOGS AND BOOKLETS

• A colorful, attractive brochure has been developed by S. C. Johnson & Son, Inc., Racine, Wis., to tell the story of Johnson's Wax-Fortified Paints. Entitled **"What's Ahead in Paints?"** the brochure describes the efficiency and high light-reflective values of these paints and the colorful illustrations include a hospital operating room in use. Copies are available for the maintenance and housekeeping departments as well as for the administrator. **(Key No. 2753)**

• A manual containing suggestions for planning health centers and hospitals, specifications for standardized hospital casework units and indexed under 48 separate headings covering information from autopsy room to x-ray department has been published by the Kewaunee Mfg. Co., Adrian, Mich. Entitled **"Casework for Hospitals, Clinics and Medical Centers,"** the book is a valuable addition to the reference library of any hospital architect or administrator. **(Key No. 2767)**

• **"Basic Data on Pollens and Spores"** is the title of a comprehensive booklet designed to assist in the diagnosis and treatment of hay fever. It was prepared by the Botanical Research Department, Abbott Laboratories, North Chicago, Ill. **(Key No. 2766)**

• **Consultant Service** to help hospitals and other institutions in planning food service is being offered by Vacuum Can Co., 25 S. Hoyne Ave., Chicago 12. The company is offering this service, which consists of suggesting menus, ways to save time, money and labor and assisting with other food service planning problems, at no cost or obligation. **(Key No. 2770)**

• To obtain a check on the periodic removal of grease from **grease interceptors** and thus effect maximum benefits from their installation, Josam Mfg. Co., 384 Empire Bldg., Cleveland, Ohio, has prepared an attractively printed card containing spaces in which to write the dates of each cleaning. In this way employes will be reminded to keep this equipment operating at full efficiency. **(Key No. 2712)**

• Safety treads for stairs, ramps, ladders and other parts of the hospital where protection of this type is needed are described and illustrated in the 16 page **Catalog No. 45** recently released by Wooster Products, Inc., Wooster, Ohio. Suggested applications for both Safe Groove and Abrasive Cast treads, tables of standard maximum sizes and complete specifications are included. **(Key No. 2755)**

Address manufacturers for further information and prices—or use Readers' Service blank on page 256

• **"Announcing Fenestra Building Panels"** is the title of a booklet which gives interesting information on these new metal building units. Issued by Detroit Steel Products Co., Building Panels Div., 2250 E. Grand Blvd., Detroit 11, Mich., the booklet offers interesting new ideas in construction. **(Key No. 2557)**

• Clinical information on **Bornex,** the potent, non-irritating emulsion for the extermination of head, body and crab lice, is presented in a folder prepared by Wyeth, Inc., Philadelphia 3, Pa. **(Key No. 2729)**

• Equipment for viewing, projecting and binding 2 by 2 inch **Kodachromes** is illustrated and described in a pamphlet just issued by Clay-Adams Co., Inc., 44 E. 23rd St., New York 10. **(Key No. 2604)**

• **A Teaching Kit on Cereal Grains,** which should prove of considerable value in nutrition classes, has been prepared by Ralston Purina Co., Checkerboard Square, St. Louis 2, Mo. The kit includes a wall chart on whole wheat, a wall chart on adequate diets and a pamphlet on cereal grains. **(Key No. 2720)**

• The helpful **"Informational Kit"** containing full data and specifications on terrazzo and mosaics which was prepared by the National Terrazzo and Mosaic Association, 1420 New York Ave., N. W., Washington 5, D. C., has been revised in format and the material brought up to date. A special bulletin has been added on plastic strips which are now being used to replace brass. **(Key No. 2638)**

• The full line of **HCE Infant Incubators** manufactured by Hospital Cabinets and Equipment, Inc., 1700 Walnut St., Philadelphia 3, Pa., is described and illustrated in a catalog just released. In addition to the de luxe model, full information is included on the standard model, which contains an ice chest instead of the electric refrigeration unit, and the utility model. **(Key No. 2668)**

• The line of **Nelaton Catheters and Surgical Tubes** available from the Miller Sundries division of the B. F. Goodrich Co., Akron, Ohio, is illustrated in a broadside which gives details of the construction and properties of these items. **(Key No. 2664)**

• A new wall chart providing **"Oiling and Maintenance Instructions, Hoffman 'Straight-Line' Flatwork Ironer"** has been added to the line of maintenance literature prepared by United States Hoffman Machinery Corp., 105 Fourth Ave., New York 3. In addition to general instructions there is a large illustration of this piece of equipment with each part clearly marked. **(Key No. 2663)**

• **"The Modern Way to Avoid Boiler Troubles"** is the title of Bulletin No. 33 recently issued by the American K.A.T. Corp., 331 Madison Ave., New York 17. The use of the all-colloidal water treatment in more efficient steam generation, elimination of shutdowns and preservation of equipment are some of the points covered. **(Key No. 2719)**

TO HELP YOU get information quickly on new products we have provided this convenient Readers' Service Form. Check the numbers of interest to you and mail the coupon to the address given below. If you wish other product information just list the items and we shall make every effort to supply it.

Bessie Covert,
Editor, "What's New for Hospitals"

- ☐ 2509 Sparkproof Plastic Flooring
- ☐ 2557 "Announcing Fenestra Building Panels"
- ☐ 2585 Salicresin Cream
- ☐ 2604 Kodachrome Equipment
- ☐ 2638 "Informational Kit"
- ☐ 2644 Staromatic Dairy
- ☐ 2646 Metallic Sutures
- ☐ 2647 Skin Graft Knife
- ☐ 2648 "Tom Thumb" Tray
- ☐ 2658 Calcium Levulinate
- ☐ 2659 Libejex
- ☐ 2660 Surgeons' Detergent
- ☐ 2663 "Maintenance Instructions"
- ☐ 2664 Nelaton Catheters and Surgical Tubes
- ☐ 2668 HCE Infant Incubators
- ☐ 2679 Spreader Type Stoker
- ☐ 2680 Sun Lamp Bulb
- ☐ 2683 Colored Surgical Photography
- ☐ 2687 Fire Resistant Paint
- ☐ 2688 Explosion-Proof Motor
- ☐ 2691 Synthetic Latex Operating Pads
- ☐ 2695 Ironing Table
- ☐ 2703 Individual Radio Speaker
- ☐ 2706 Sedative-Antispasmodic
- ☐ 2712 "Grease Removal Record"
- ☐ 2719 "Avoid Boiler Troubles"
- ☐ 2720 Teaching Kit on Cereal Grains
- ☐ 2729 "Bornex"
- ☐ 2733 Gastro-Intestinal Sutures
- ☐ 2735 Tomac Sanitary Napkins
- ☐ 2737 Diet Card and Napkin Holder
- ☐ 2742 Portable Infrared Drying Lamps
- ☐ 2753 "What's Ahead in Paints?"
- ☐ 2755 Catalog No. 45
- ☐ 2766 "Basic Data on Pollens and Spores"
- ☐ 2767 "Casework for Hospitals, Clinics and Medical Centers"
- ☐ 2770 Consultant Service

I would also like to have information on the following products

_____

_____

NAME _____ **TITLE** _____

HOSPITAL _____

STREET _____

CITY _____ **STATE** _____

MAIL TO Readers' Service Dept., The Modern Hospital Publishing Co., Inc.
919 N. Michigan Ave., Chicago 11, Ill.

Manufacturers' Plant News

W. A. Taylor & Co., 7300 York Road, Baltimore 4, Md., announces the enlargement of its production and storage facilities. The enlarged plant makes it possible to fill orders more promptly since a larger inventory of all types of comparators—pH, chlorine, phosphate and medical—can be carried. **(Key No. 2771)**

U. S. Slicing Machine Co., La Porte, Ind., has increased its line of food service equipment through appointment as exclusive national distributor of Wells "Quikut" meat, bone and fish saws manufactured by the Wells Mfg. Corp., Three Rivers, Mich., according to advices recently received. **(Key No. 2772)**

Printed in U.S.A.